

Parkway Medical Group
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Authorization to Release Medical Records

Patient's Name _____

Patient's Address _____

Patient's Daytime Telephone Number _____

Patient's DOB _____

Patient's Social Security Number _____

Requested from: _____ Fax Number: _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records. **This authorization includes consent for release of alcohol, drug, psychiatric, pregnancy, sexually transmitted diseases, HIV testing, AIDS, cancer, cancer testing. I agree that a copy of this authorization or a fax of this authorization shall be as valid as the original.**

_____ SEND ALL MY RECORDS
_____ SEND ONLY RECORDS REQUESTED _____

SEND RECORDS TO: _____

**PARKWAY MEDICAL GROUP
MEDICAL RECORDS
333 GASHES CREEK ROAD
ASHEVILLE, NC 28803**

Patient's Signature: _____

Date _____ Witness _____

THIS AUTHORIZATION EXPIRES ON _____