Comprehensive care for the entire family

Gary A. Curran, MD
Melissa Martinez, PA-C

www.PisgahFamilyHealth.com
(828) 670-7077

Request for Release of Medical Records

Patient Name: _____

Patient Address: _____

Patient Date of Birth:_____ Patient Phone #:_____

☐ **Obtain From** ☐ **Send To**
Dr. Gary Curran
Pisgah Family Health
220 Ridgefield Court
Asheville, NC 28806
828-670-7077 **Fax. 828-670-7035**

☐ **Obtain From** ☐ **Send To**
Name/Office _____
Address _____
_____
Fax _____
Phone _____

Reason for this release:
☐ Transfer of Care ☐ Referral Appt ☐ Insurance Request ☐ School/Employer Request
☐ Other: _____

Consent
I hereby authorize disclosure of medical records for the above named patient. This authorization is valid until I revoke it in writing. Revocation will not take any effect on any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person/class of persons/facility receiving it and would no longer be protected by federal regulations. I understand that the medical provider to whom this information is furnished may not condition their treatment of me on whether or not I sign the authorization.

Signature _____ Date_____

Witness
Signature _____ Date_____