



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 _____