Gaston Medical Partners - FAX to 855-604-8103

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:	Date of Birth:
Street Address:	Last 4 of SSN:
City, State, Zip:	Phone: ( )
Email Address: *We will use reasonable means to protect the security and confidentiality of emails sent and received, but we cannot guarantee the security and confidentiality of all email communications.*	

RELEASE FROM	**RELEASE TO**
Name (Facility or Practice):	Name of Individual:
	Name of Organization: Gaston Medical Partners
	Relationship:
	Street Address or PO Box: 924 Cox Road
	City, State, Zip: Gastonia, North Carolina 28054
	Fax: 855-604-8103 Phone: 704-800-4268
	Email: NONE

REASON FOR RELEASE (for example: personal, insurance, disability, workers' compensation, legal):

DATES OF RECORDS TO RELEASE	FROM ___ / ___ / _____ TO ___ / ___ / _____	**OR** All Dates (check box) ☐

WHAT TO RELEASE			
☐ **All Records** (not including psychotherapy notes)			
☐ **Hospital Records** (select below)			
☐ History & Physical	☐ Progress Notes	☐ Operative Reports	☐ Cardiac Reports/EKG
☐ Discharge Summary	☐ Emergency Record	☐ Consultation Reports	☐ Laboratory Reports
☐ Diagnostic Test Results	☐ Allergies	☐ Radiology/X-Ray Reports	☐ Billing Information
☐ Medications	☐ Physician Orders	☐ Pathology Reports	☐ Other:
☐ **Physician/Office/Clinic Records** (select below)			
☐ Office Visits	☐ Diagnostic Test Results	☐ Medications	
☐ Physical Exam	☐ Laboratory Reports	☐ Billing Information	
☐ Consultation Reports	☐ Radiology Reports	☐ Other:	
Delivery Method (charges may apply)**:** ☐ Encrypted Email ☐ Regular U.S. Mail ☐ Fax ☐ Pick up ☐ CD ☐ Other (specify):			

I understand that:

- I can revoke this authorization at any time. I must cancel in writing and send cancellation to releasing facility or practice above. Any cancellation will apply only to information not already released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits. A fee may be charged for providing the protected health information. I have a right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless another date or event is written here: _____

If you are requesting your own records:	**If you are requesting records on behalf of another person:**
Signature:	Signature:
Print name:	Print name:
Date/Time:	Date/Time:
	Relationship to Patient (written proof may be required): ☐ Parent ☐ Guardian ☐ Next of Kin ☐ Executor/Administrator/Attorney-in-Fact ☐ Healthcare Agent/POA ☐ Other (specify):

After completed, please FAX to 855-604-8103