Authorization for Release of Medical Records

I, _____, do hereby consent and authorize

_____

to release to _____
all medical records relating to my (or my dependent child's) identity, diagnosis, prognosis and treatment, psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, or hepatitis. I understand the extent or nature of the medical information to be disclosed includes:

_____

Furthermore, I understand that this authorization is revocable by me at any time should I provide a written, signed notice of revocation to Hugh Chatham Medical Group, except to the extent that any action has already been taken on this release. Otherwise consent will remain in force for 90 days.

Special Limitation or restrictions (if any): _____

_____

_____ _____

Signature of Patient Date Signature of Witness Date

_____

Signature of Parent/Legal Guardian Date

Patient's Date of Birth: _____/_____/_____

Patient's Chart Number: _____

Patient's ID _____

180 Parkwood Drive | Elkin, NC 28621
336-527-7000 | www.hughchatham.org

Hugh Chatham Medical Group
an affiliate of Hugh Chatham Memorial Hospital