BILTMORE OB-GYN
24 MEDICAL PARK DRIVE
ASHEVILLE, NC 28803
www.biltmoreob-gyn.com
***828-277-7727 fax* 855-619-9998**

CONSENTING AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Name _____ **Date of Birth** _____

Address _____

Phone (Home) _____ **(work)** _____

This is to certify that I (Patient)_____ **authorize transfer of records as indicated below:**

RELEASE FROM DOCTOR:	**RELEASE TO DOCTOR:**
Name_____	**Name**_____
Address_____	**Address**_____
_____	_____
Phone_____**Fax**_____	**Phone**_____**Fax**_____

Records Requested:

LABS ONLY	**PAPS ONLY**	**US/RADIOLOGY ONLY**
LAST 3 YEARS	**ALL RECORDS**	**OTHER**_____

If *ALL* information is requested it *WILL INCLUDE* information on *AIDS* (Acquired Immunodeficiency Syndrome) or *HIV* (Human Immunodeficiency Virus) infection, psychiatric care and /or psychological assessment, and treatment for alcohol and/or drug abuse.

Biltmore OB-GYN chart number_____**Physician**_____

ALL INFORMATION RELEASED FROM THIS OFFICE WILL BE CONFIDENTIAL AND THE PRIVACY OF THE PATIENT WILL BE UPHELD AS REQUIRED BY LAW.

PLEASE NOTE: THERE WILL BE A MINIMUM FEE OF $10.00 OR $0.75 PER PAGE UP TO 25 PAGES; $0.50 PER PAGE FOR 26-100 PAGES; $0.25 PER PAGE AFTER 100. PAYMENT IN FULL MUST BE RECEIVED BEFORE RECORDS ARE COPIED AND MAILED OR FAXED. RECORDS ARE RELEASED BY PAPER ONLY, NO CD OR EMR RECORDS SENT.

The purpose of this disclosure is: (circle one)

***MOVING FROM AREA**	***CHANGING PHYSICIANS**	***OTHER**
***ADDITIONAL PHYSICIAN (I.E. FAMILY DOCTOR)**		***INSURANCE CLAIM**

I understand that I have the right to revoke this authorization, except to the extent that action has been taken in reliance on this authorization or if applicable, during a contestability period. I understand in order for a revocation to be effective, it must:

- ***Be written***
- ***Be sent and received by the Privacy Officer of the covered entity to whom I made this authorization***
- ***Include my name, address, and patient number if applicable***
- ***Include the effective date of this authorization and the recipient(s) according to this authorization***
- ***State a desire to revoke this authorization***
- ***Be dated and signed by me***

I fully understand and accept the terms of this authorization.

Patient Signature_____**Chart #**_____**Date**_____**Exp. Date**_____

Witness Signature_____**Date**_____

NAME_____**CHART #**_____**DOB**_____