**Vance Family Medicine**
**381 Ruin Creek Road**
**Henderson, NC 27536**
**Phone: (252) 430-0666**
**Fax: (252) 430-7503**

# Consent for Release of Protected Health Information

Send To/Request From: _____
Physician/Office Name

Address: _____
_____

I do hereby consent and authorize the above listed clinic to release copies of my medical records, including lab results and x-ray results ordered by a clinician at the listed clinic, which are part of my medical records. PLEASE NOTE: this authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as the original release. Please send copies of all requested information as soon as possible.

**Check ( ✔ ) and complete the appropriate items:**

- ❑ SEND COMPLETE MEDICAL RECORD
- ❑ SEND RECORDS **FROM** (DATE) _____ / _____ / _____
  **TO** (DATE) _____ / _____ / _____
- ❑ SEND MY RECORDS PERTAINING TO _____

Purpose of Request (ex: insurance, legal, personal, changing MD): _____

Patient Name: _____
Date of Birth: _____
Social Security #: _____

Patient/Guardian Signature: _____
Date: _____ / _____ / _____

Witness Signature: _____
Date: _____ / _____ / _____