# DeSantis Family Practice, PLLC

## Consent for Release of Medical Records

Patient Information:

Patient Name: _____

Patient Date of Birth: _____

**RELEASE MY MEDICAL RECORDS FROM:**

Practice Name/City & State: _____

Previous Family Doctor Name: _____

Practice Phone Number: _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics 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 in relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and AIDS-related Syndromes. It also includes any information concerning Cancer, Cancer testing, and Cancer results. I agree that a copy of this release or fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address or via fax listed below:

SEND ALL MY RECORDS FROM (DATE) _____ TO (DATE)_____

SEND **ALL** IMPORTANT RECORDS ☐

**Send Records to:**
**DeSantis Family Practice, PLLC**
**10 Third Ave NE, Suite 500**
**Hickory, NC 28601**
**Phone: 828-304-6363**
**Fax: 828-304-0033**

_____
Patient Signature

_____
Date

_____
Witness