GRACE G. EVINS, MD
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ASHEVILLE, NC 28803
PHONE 828-575-9562 FAX 828-575-2884

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE NOTE: There will be a charge for a copy of our records. Our records will not be sent until payment is made. You may or may not receive an invoice for records sent from another office, to us, depending on that offices' policy. *Please check one option, and complete below:*

☐ Send Records **From:** Grace G. Evins, MD, **To** name / address below
or
☐ Request Records **From** name / address below, **To** Grace G. Evins, MD

Doctor or Facility Name _____ Phone _____

Address _____ City, State, Zip _____

Patient's Full Name _____ Patient's Date Of Birth _____

Street Address _____

City, State, Zip _____ Daytime Phone _____

Date Range Of Records Requested: From _____ To _____

Specific records requested, within the above date range:

☐ Problem List ☐ Medications List ☐ Pap Results ☐ Lab Results
☐ Obstetric History ☐ Progress notes ☐ Radiology Results ☐ All Records

Purpose of disclosure:

___ Insurance ___ Workers Comp ___ Referral To Specialist
___ Personal ___ Legal Investigation ___ Disability Determination
___ Transferring Care To Another Dr ___ Other (specify) _____

___ I do, ___ I do NOT authorize release of information related to AIDS infection, psychiatric care, psychological assessment, and treatment for alcohol and/or drug abuse. I authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.

Signature of individual, or guardian, or personal representative of patient's estate _____ Date Signed _____