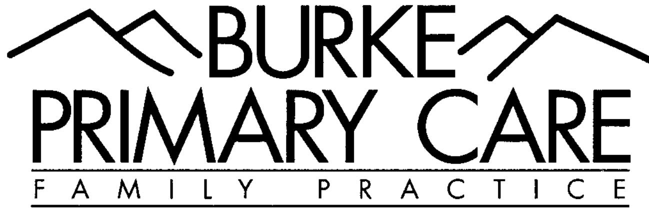

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103 Medical Heights Drive
Morganton, NC 28655
Voice: (828) 437-4211

PLEASE RETURN THIS FORM WITH RECORDS TO:

FAX: (828) 438-4109

Name:______________________________

Address:______________________________

Address:______________________________

Birthdate:______________________________

Telephone:______________________________

CONSENT TO RELEASE OR RECEIVE MEDICAL INFORMATION

I, hereby authorize and request that you release copies of my medical record:

TO: Burke Primary Care

FROM:______________________________

Phone:______________________________

Fax:______________________________

FROM: Burke Primary Care

TO:______________________________

Phone:______________________________

Fax:______________________________

MEDICAL INFORMATION REQUESTED:

☐ Complete Record ☐ Limit to Specific Information/Reports______________________________

Please Note: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes.

AUTHORIZATION:

This authorization will automatically expire 90 days from the date of signature. At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time prior, except to the extent that action has been taken in reliance on this authorization.

Signed:______________________________ Date:____________________

Parent/Guardian

OFFICE USE ONLY:

Chart #:____________ Provider:______ Appt Date:____________ Directive:____________