TABLE ROCK
FAMILY MEDICINE
301 LINVILLE STREET
P.O. BOX 837
GLEN ALPINE, NC 28628

RECORDS RELEASE FORM

I, _____, authorize Table Rock Family Medicine to obtain and / or release my medical information from / to the persons listed below. I understand and agree that my medical records may be release by facsimile (fax) if necessary.

Send records to:

Name: _____
Address: _____

Name: _____
Address: _____

Obtain records from:

Name: _____
Address: _____

Name: _____
Address: _____

Release records to:

Name: _____
Address: _____

Name: _____
Address: _____

_____
Signature of Patient Date of Birth Home Address

_____
Signature of Guardian/Parent Relationship to Patient Date

It is understood that the above information to be released to Table Rock Family Medicine, PLLC is fully protected by the laws establishing the confidentiality of information acquired by Table Rock Family Medicine, PLLC.

Authorization must be signed both by the patient and the nearest relative/guardian if the patient is under 18 years of age or by the nearest relative/guardian if the patient is incompetent or otherwise incapacitated.