

NORTH CHARLOTTE FAMILY MEDICINE, PLLC
2801 CRISMAN ST.
CHARLOTTE, NC 28208
(704) 392-4108-OFFICE / (704) 392-4109-FAX

Medical Release Form
To
North Charlotte Family Medicine, PLLC

Patient Information:

Last Name

First Name

MI

DOB

Phone Number

Address

Information Requested:

I, _____, authorize **North Charlotte Family Medicine, PLLC** to obtain my Medical Records from:

Name: _____

Address: _____

Phone: _____ Fax: _____

COMPLETE MEDICAL RECORDS

IMMUNIZATION RECORD

OTHER _____

Purpose for request:

Moving

Change of PCP

Other

I hereby authorize the above named entities to obtain any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, lab results (including HIV/STD testing), or other protected information unless otherwise excluded. I am aware the North Charlotte Family Medicine, PLLC cannot control how the recipient uses or shares this information and the laws protecting confidentiality may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.

Signature of patient, parent or guardian

Relationship to Patient

Date