Vance Family Medicine
381 Ruin Creek Rd.
Henderson, NC 27536
Phone: (252) 430-0666 Fax: (252) 430-7503
Email: info@vancefamilymedicine.com

Patient Name: _____ Date of Birth: _____
I (patient listed above) request & authorize the release of my health information listed below:

☐ **Request From** ☐ **Requested To**

Name/Facility: _____
Address or Location: (If Multiple Offices) _____
Phone: _____ Fax: _____
Email: _____

Please select how you want records requested or submitted:
☐ **Email** ☐ **Print** ☐ **Fax**

Information To Be Disclosed: (check the appropriate boxed and include other information where indicated)
☐ Summary Health Information
- ☐ History & Physical (e.g. doctor visit)
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Immunization Records
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Other _____

Dates Requested:
- ☐ Specific Dates: _____ to _____
- ☐ All Dates

This authorization will expire on the following date: _____
If I fail to specify an expiration date, this authorization will expire one year from the date on which it's signed.

Date: _____
Signature of Patient or Legal Representative: _____
(Printed Name) _____
Signature of Witness: _____

*If requesting Medical Records to be printed by Vance Family Medicine there will be a charge of $15.00 prior to records being received.