Horizon Internal Medicine

138-B Dublin Square Rd	1380 Eastchester Dr Suite 105
Asheboro, NC 27203	High Point, NC 27265
P. 336.610.1300	P.336.660.6338
F. 336.672.6001	F.336.307.3226

CONSENT TO RELEASE MEDICAL RECORDS

From: ____

____

____

Please disclose the following:

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Lab/Diagnostic Records
- ☐ Other: ________________________

To be used for the following purposes:

- ☐ Per Patient Request
- ☐ Continuing Health Care
- ☐ Weight Management Program
- ☐ Other: ________________________

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during my care. These may or may not include treatment of substance abuse, other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc. unless herein excepted:____

By signing below, I herby authorize and request that you release my medical records and/or other information concerning my healthcare and/or treatment to:

Horizon Internal Medicine

Imran Haque, MD

I also understand that I may revoke this authorization at any time by submitting a written notification to the address above. This notice will not apply to actions taken prior to the date my revocation of authorization is received. I understand that this authorization expires twelve months from the date, unless the need for disclosure is satisfactorily met within that twelve month period or if I provide written revocation of this authorization.

PATIENT AUTHORIZATION

PATIENT NAME:____________________________________ DATE OF BIRTH: ______/______/______

(First, middle and last name)

____

Signature of Patient or Authorized Representative

____

Date

____

Disclosure Expiration Date