

# Request for Release of Medical Records

**I request the release of my medical records from:**

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**I request my medical records be released to:**

Dr. Gary Curran  
Pisgah Family Health  
220 Ridgefield Court  
Asheville, NC 28806  
828-670-7077 Fax. 670-7035

**The purpose of this release is:** Primary Care

**The duration of this release is:** One year from the date signed below.

**Please release the following records:** Any and all records of medical care.

## Consent

This information is intended for use by Dr. Curran and Pisgah Family Health only. I have a right to privacy of my medical records as regulated by federal HIPPA rules, and I hereby waive this right only with regards to the records and organizations listed above. I have the right to receive a copy of this release. I may revoke this release at any time by a written request. I am aware that the records released may contain personal information related to medical and psychiatric treatments, drug and alcohol abuse, and HIV status. I may refuse to sign this authorization for any reason and I understand that such refusal will not affect my ability to continue care with Dr. Curran at Pisgah Family Health.

Name of Patient \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian must sign for a minor child)

Witness  
Signature \_\_\_\_\_ Date \_\_\_\_\_