

Charleston Internal Medicine, Inc.

MEDICAL RECORDS REQUEST

Patient Name: _____ Date of Birth: _____ SS# _____

I hereby authorize:

Facility Name _____

Provider Name _____

Address _____

City, State and Zip _____

Phone# _____ Fax# _____

This release includes the following records:

_____ Any and All Records from First Visit to Present

_____ Records from _____ To _____

Reason for Request _____ Transfer Care _____ Insurance _____ Personal _____

Only my (Mark Below):

_____ Laboratory From _____

_____ Imaging From _____

_____ Progress Notes From _____

_____ Hospital Visits From _____

_____ Other: _____ From _____

Please send Records to:

Charleston Internal Medicine, Inc.

3701 MacCorkle Avenue, SE

Charleston, WV 25304

Telephone 304-720-2345 Fax 304-720-2347

Patient Signature: _____ Date _____