Charleston Internal Medicine, Inc.
3701MacCorkle Avenue, SE
Charleston, WV 25304
304-720-2345
Fax 304-720-2347

Patient Name: _____ Date of Birth: _____

I hereby authorize Charleston Internal Medicine, Inc. (CIM) to release my medical records to:

_____
Name of Practice/Provider

_____
Mailing Address

_____
City State Zip

This release includes forwarding the following records:

_____Any and All Records from First Visit to Present

_____ Records from _____ To _____
Date Date

Mark Any Type of Records You DO NOT want released (Mark all that apply):
If nothing is marked, all records will be released.

_____ CIM Ordered Laboratory
_____ CIM Ordered Imaging
_____ CIM Progress Notes
_____ CIM Hospital Visits

_____ Behavioral/Mental Health Records
_____ Alcohol/Drug
_____ Sexually Transmitted Disease Records
_____ HIV/AIDS Records
_____ Other- Must List Specific Request:
_____

I **am requesting these records be sent for the following purpose:**

____ Establish with new Primary Care Provider

____ Other- Explain: _____

**** NOTE** There is a charge for records sent directly to patients. There is no charge for records sent to another healthcare professional.**

_____

I want the records to be sent in the following manner:
____ On Paper _____ On Electronic Media (Disk)
NOTE- Records will be sent on Electronic Media (CD) unless otherwise indicated.

Charleston Internal Medicine, Inc., its physicians and employees are released from legal responsibility or liability for the release of the above requested information.

Patient's Signature: _____ Date: _____ (08/27/18)