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 and 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 <u>DO NOT want released</u> (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: ____

Please Note: Any patient transferring records to another primary care office that is within our patient service area will not be taken back into the practice as a patient.

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 providers, and employees are released from legal responsibility or liability for the release of the above requested information.

Patient's Signature: ______________________________ Date: __________

(08/04/23)