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

OR

_____ 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_______________

(Form- Medical Records Updated 08/04/23)