MEDICAL RECORDS RELEASE FORM

I do hereby consent and authorize UNC Regional Physicians to release copies of my medical records.

Patient Name	**Medical Record Number**
Address	
City, State and Zip Code	**Phone**
Date of Birth	**Social Security Number** *(Last 4 digits only)*

RECORDS REQUESTED FROM UNC REGIONAL PHYSICIANS

Name of Person or Facility	
Address	
City, State and Zip Code	**Phone**
Date of Birth	**Social Security Number** *(Last 4 digits only)*
Email	**Fax**

RECORD TO USE OR DISCLOSE TO

Name of Person or Facility	
Address	
City, State and Zip Code	**Phone**
Date of Birth	**Social Security Number** *(Last 4 digits only)*
Email	**Fax**

Please select all the specific documents that apply to your request:

- ☐ Clinic Notes
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Urgent Care
- ☐ Nurses Notes
- ☐ Operative Reports
- ☐ EKG. EEG. EMG
- ☐ Other _____
- ☐ Emergency Room
- ☐ Doctor Consults
- ☐ Physician Orders