Charlotte Lung and Health Center
1918 Randolph Road, Suite 440 Charlotte, NC 28207
Phone 704/342-8143 Fax 704/926-8044

Patient Request to Review or for Copies of Records

Patient Information:
Name of Patient _____ Date of Birth _____

Name, address & phone of Covered Entity authorized to release information:

_____

_____

_____

Name & address for mailing or indicate if pick-up by person other than patient – include contact phone number

_____

_____

_____

Description of information to be released/reviewed at the request of the patient:

_____

_____

Patient Information

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

_____Date _____
Signature of Patient or Personal Representative

_____ _____
Print or Type Name of Patient or Personal Representative Contact Phone Number

_____
Description of Personal Representative's Authority (attach necessary documentation)

Revised January 2010