Larry F. Berman, M.D., M.S.P.H, P.C.

Adult & Adolescent Internal Medicine

10620 Park Rd. Suite 128♦Charlotte, NC 28210 Phone 704.542.6111♦Fax 704.542.1239

Medical Records Release Authorization Form

Date of Request: _____

☐ Request Records From: ☐ Send Records To:

_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Dates of Treatment:

- ☐ All
- ☐ Past 5 Years
- ☐ Most Recent Visit
- ☐ Most Recent Labs/Radiology
- ☐ Other: _____

Delivery Method (check one):

- ☐ Fax (preferred)
- ☐ Mail

Purpose of Release (check one):

- ☐ Request of individual/personal
- ☐ Other: _____

I hereby request that my medical records, including but not limited to office notes, radiology reports, laboratory analysis and EKGs, be released to/by Larry F. Berman, M.D.
I understand that to cancel this request at any time, I must supply the releasing office notification in writing.
This permission expires one year after the date of my signature.
Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Patient/Guardian Signature: _____

Patient's Full Name (Print): _____

Last 4 Digits of Patient's SSN: _____ DOB: _____