Island Family Medicine, PLLC
J. Seaborn Blair III, MD

Michael Davanzo, PA-C
Rachel Pearson, PA-C
Hailee Martin, PA-C

Phone: 910.329.9916
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Medical Records Request

1. I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

_____
Fax Number

2. TO RELEASE TO:

_Island Family Medicine_____
Name of receiving person/organization
_PO BOX 2400_____
Street Address
Surf City, NC 28445
City State Zip Code
_910-329-0308_____
Fax Number

3. **INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Record ☐ Immunization

4. **RECORDS FROM THE TIME PERIOD:** ____/____/____ through ____/____/____

or **ALL RECORDS** ☐

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

☐ Continued Medical Care ☐ Personal

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient's Name (Please Print) _____

Patient's Signature: _____ Date: _____

Date of Birth: _____

Home Phone: _____