

**DATE:** \_\_\_\_\_

**NAME:** Medical Records Request

**RE:** AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

**FAX NUMBER:** (336) 599-4025

**SENDER:** \_\_\_\_\_

**ATTENTION:**

This message and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this message in error please notify the system manager. This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this message. Please notify the sender immediately if you have received this message by mistake. If you are not the intended recipient you are notified that disclosing, copying, distributing or taking any action in reliance on the contents of this information is strictly prohibited.