



Phone: 828-505-2664

Fax: 828-505-2560

www.avorahealth.com

1000 Centre Park Drive Asheville, NC 28805

Medical Records Request Form

I, _____ request that my medical records or other health care information, including intake forms, chart notes, reports, and other written information concerning my health and treatment during the period of _____ to _____; be released from the following medical clinic:

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send the medical records to:

AVORA Health

1000 Centre Park Drive

Asheville, NC 28805

Phone: (828) 505-2664

Fax: (828) 505-2560

Signature: _____ Date: _____

Patient's Printed Name: _____ Date of birth: _____