MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the release of my medical records or other health care information; including care plan, chart notes, treatment and/or medication records, progress notes, and/or any other pertinent correspondence to Keystone Laboratories. This information may be requested by my insurance provider in effort to determine benefit eligibility and proper claim submission. I authorize the release of the necessary requested information via secure MAIL/EMAIL/FAX to:

Keystone Lab
Billing Office Support Services
3 McDowell Street
Asheville, NC 28801
Phone: 800/635-5765
Fax: 855/204-3222
Email: billing@keystonelab.com

Date: ______________________________

Patient Name: ______________________________

Patient Date of Birth: ______________________________

Patient Address: ______________________________

City, ST, Zip code: ______________________________

Patient Phone Number: ______________________________

Patient Signature:

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Patient Printed Name:

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