CAROLINA ENDOCRINE, P.A.
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www.carolinaendocrine.com

Authorization to Release and/or Request Medical Records

Patient Name: _____ Date of Birth: _____

Phone: _____

Release of Records FROM:

Practice/Provider Name: _____

Phone: _____ Fax: _____

Release of Records TO:

Practice/Provider Name: _____

Phone: _____ Fax: _____

Purpose: ☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Disability

☐ Changing Physician ☐ Moving ☐ Other: _____

Information to Be Released:

☐ All Records

☐ History & Physicals

☐ Clinic Notes

☐ Labs/Pathology

☐ Diagnostic Reports (i.e. Radiology, Ultrasound, etc.)

☐ Other: _____

I understand that I may revoke this authorization at any time by providing my written revocation to Carolina Endocrine, P.A. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be 1 year from the date of signature. The information to be released or disclosed may include information relating to sexually transmitted diseases, HIV/AIDS, alcohol and drug abuse, and/or mental health. I authorize the release or disclosure of this type of information. My signature is required to validate this voluntary authorization. If I do not sign this authorization, Carolina Endocrine, P.A. will still provide treatment and seek payment for services.

_____ _____

Patient/Guardian Signature Date

_____

Printed Name of Patient/Guardian