Carolina Endocrine, P.A.

Authorization for Release of Medical Information

I, _____ hereby authorize:

Carolina Endocrine, P.A.
3840 Ed Drive, Suite 111
Raleigh, NC 27612
Phone: (919) 571-3661 Fax: (919) 571-3290

To release and forward my medical records, including machine readable medical and demographic data to the following providers or authorized recipient(s) (**LIST PROVIDER NAME, PRACTICE NAME, AND PHONE NUMBER):**

1._____

2._____

Please check reason for transfer of records:

□ Moving □ Primary Care Doctor □ Changing endocrinologist /why? _____

□ Second Opinion □ Other _____ _____

Patient Name: _____

Date of Birth: _____

Treatment Dates: _____

The information disclosed may include the following (<u>please circle</u>):

ALL Clinic Notes Labs/pathology X-ray reports ER Hospitalizations

Operative/Procedure Note's History & Physicals Urgent Care HIV/AIDS

I understand that this authorization can be revoked at any time and that it *expires one year from the signature date.*

Patient Signature: _____ Date: _____

Print Guardian Name (if applicable) _____

Guardian Signature (if applicable) _____