Carolina Endocrine, P.A.

Authorization for Request of Medical Information

I, _____ hereby authorize:

Name of Provider and/or Facility: _____

Address: _____
Street City/Town State Zip

Phone: ( ) _____ **Fax:** ( ) _____

To release and forward my medical records, including machine readable medical and demographic data to:

Carolina Endocrine, P.A.

3840 Ed Drive, Suite 111
Raleigh, NC 27612
Phone: (919) 571-3661
Fax: (919) 571-3290

Patient Name: _____

Date of Birth: _____

Day Time Phone: _____

Treatment Dates: _____

Purpose of the Requested use of Disclosure: _____

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

Clinic Notes Labs/pathology X-ray reports ER Hospitalizations

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

Social Services Disability Discharge Summary's Mental Health/Drugs/Alcohol ALL

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

Print Patient Name: _____ Date: _____

Patient Signature: _____

Parent/Guardion Signature: _____ **Rev. 05/2016**