Release of Medical Information

Cary Endocrine & Diabetes Center

Patient's Name:	Date of Birth:
Former Name (if applicable):	Social Security #:

I request and authorize CARY ENDOCRINE & DIABETES CENTER, P.A. to release healthcare information (including demographic data) of the patient named above to:

Name of Clinic/MD:

☐ Fax to: ☐ Mail to:

This request and authorization applies to:	From Date:

☐ Clinic Notes ☐ Laboratory Reports ☐ Ultrasounds ☐ Radiology Reports

☐ All medical records

☐ Other:

☐ Yes ☐ No	I authorize the release of HIV/AIDS testing and other communicable diseases. I understand that the person(s)/clinic listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
☐ Yes ☐ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s)/clinic listed above.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED UNLESS OTHERWISE SPECIFIED.

Unless I revoke this authorization, I wish it to expire on: _____ / _____ / _____.
(Date mm/dd/yyyy)

Patient Signature:		Date Signed:
Parent/Guardian Signature:	Relationship to Patient:	Date Signed: