

**Release of Medical Information to
Cary Endocrine & Diabetes Center, P.A.**



Patient's Name:		Date of Birth:
Former Name (if applicable):		Social Security #:
I request and authorize (Name of clinic or MD): _____ to release healthcare information (including demographic data) of the patient named above to:		
Name of Clinic/MD: Cary Endocrine & Diabetes Center, P.A.		
Fax records to: 984-242-0212		
This request and authorization applies to:		From Date:
<input type="checkbox"/> Clinic Notes <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Ultrasounds <input type="checkbox"/> Radiology Reports <input type="checkbox"/> All medical records <input type="checkbox"/> Other:		
<input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<input type="checkbox"/> Yes <input type="checkbox"/> 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: