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.

Michael J. Thomas, M.D. **Nicole McDermott, PA-C** **Julia Warren-Ulanch, M.D.**
Courtney Koppenal, PA-C

2605 Blue Ridge Road, Suite 190
Raleigh, NC 27607
Phone: (919) 571-3661
Fax: (919) 571-3290

Patient Name: _____

Date of Birth: _____

Social Security (voluntary): _____

Address: _____

_____

Day Time Phone: _____

Treatment Dates: _____

The information disclosed may include the following (please circle and initial):

Clinic Notes Labs/pathology X-ray reports ER Hospitalizations

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

Social Services DisabilityDischarge Summary's Mental Health/Drugs/Alcohol

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: _____