Carolina Endocrine, P.A.

Authorization for Release of Medical Information

I, _____ hereby authorize:

Carolina Endocrine, P.A.
Michael J. Thomas, MD
Julia Warren-Ulanch, MD
Nicole McDermott, PA-C
Courtney Koppenal, PA-C

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

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

Name of Provider and/or Facility: _____

Address: _____
Street **City/Town** **State** **Zip**

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

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: _____