RALEIGH ENDOCRINE ASSOCIATES

Endocrinology Diabetes and Metabolism

Denis I. Becker, M.D., F.A.C.E. • Elizabeth H. Holt, M.D., F.A.C.E. • Corey D. Berlin, M.D.• Glenn M. Stall, M.D. • Shawnee D. Weir, M.D., F.A.C.E

Linda Brower, PA-C • Nancy Crowell, AGPCNP-BC • Dawn Diaz, PA-C • Lauren Hendricks, FNP • Lisa M. Hill, P.A.-C • Marjorie Pierre-Louis, FNP

Authorization to Release and/or Request Medical Records

Patient Name: _____ Former Name: _____

Street Address: _____ City, State, Zip: _____

Date of Birth: _____ Phone Number: _____

I hereby authorize Raleigh Endocrine Associates to:

_____ ***Release*** medical records to the provider/facility listed below.

_____ ***Request*** medical records from the provider/facility listed below.

Name of Provider/Facility: _____

Address: _____

Phone: _____ Fax_____

☐ **I would like my records mailed to me.*** ☐ **I will pick up my records.***

** There will be a $30 fee for records released directly to the patient*

Treatment Dates (Specify Date or Date Range): _____

Information to be Disclosed (Check all that apply):

☐Office Notes ☐Thyroid Ultrasound ☐MRI Hospitalizations:

☐ Labs/Pathology ☐Bone Density (all pages from the machine print out) ☐Admit Note ☐Discharge Summary ☐Pathology

☐Other_____ ☐Consult Notes ☐Op Notes ☐Radiology ☐ Labs

Purpose of Disclosure:

☐Request of individual /personal ☐Continuing Care ☐Changing Physician ☐Moving

☐Legal ☐Insurance ☐Disability ☐Other _____

I understand:

I may revoke this Authorization at any time by providing my written revocation to the address at the bottom of the form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be 1 year from the date of signature.

The information to be released or disclosed may include information relating to sexually transmitted diseases, HIV/AIDS, alcohol and drug abuse, and/or mental health. I authorize the release or disclosure of this type of information.

Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____

Print Name of Patient or Legal Guardian Relationship to Patient

_____ _____

Signature of Patient or Legal Guardian Date