CONSENT FOR RELEASE OF MEDICAL RECORDS

CARRBORO FAMILY MEDICINE CENTER, P.A.
610 JONES FERRY ROAD
SUITE 102
CARRBORO, NC 27510
TELEPHONE: (919) 929-1747 FAX: (919) 933-5168
E-FAX: (919) 929-4862

FROM:

PATIENT'S NAME_____

PATIENT'S DATE OF BIRTH_____

OBTAIN RECORDS FROM:

NAME OF OFFICE: _____

OFFICE ADDRESS: _____

OFFICE TELEPHONE: _____ OFFICE FAX:_____

This authorization is inclusive of ALL information contain in your files. This may include alcohol, drug, psychiatric and psychological information and information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS-related syndromes. It may also include information concerning cancer testing and cancer results. I agree that a copy of fax of this release shall be valid as this original release. This release will expire 1 year from the dated listed below.

____All Medical Records
____All Immunizations
____Latest Lab Results
____All lab Results
____All Cardiac Records
____All X-Ray Reports
____All GI records (including EGD, Colonoscopy and pathology reports)
____Last Office Visit Note
____Last two Office Visit Notes
____Last Physical Exam Note
____Other

Please send records to:

Address: _____

_____

Telephone number: _____ Fax number: _____

_____ _____ _____
Patient's Signature Date Witness to Signature

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