



**CREEDMOOR CENTRE  
ENDOCRINOLOGY**  
WHERE IT ALL COMES TOGETHER

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**Record Release Form**

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**Preferred Name:** \_\_\_\_\_ **Preferred pronoun:** \_\_\_\_\_

**Release Records From:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**Send Records To:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**Purpose:** Continuation of care  Insurance  Legal  Personal  Other \_\_\_\_\_

**Information to be released:** All records (last 2 years will be sent unless specified) \_\_\_\_\_

History & Physical		Radiology Reports		Lab Reports		Growth Charts		Pathology Reports	
Clinic Notes		Discharge Summary		Bone Age		Ultrasound or FNA		Last DXA	
Other									

Treatment Date(s) From \_\_\_\_\_ to \_\_\_\_\_

I understand that the information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services or alcohol abuse.

My signature is required to validate this authorization. This authorization is voluntary. If I do not sign this Creedmoor Centre Endocrinology will still provide treatment and see payment for services.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_