CREEDMOOR CENTRE ENDOCRINOLOGY
WHERE IT ALL COMES TOGETHER

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Record Release Form

PATIENT NAME: _____ **DATE OF BIRTH**: _____

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: _____