CREEDMOOR CENTRE ENDOCRINOLOGY

WHERE IT ALL COMES TOGETHER

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

RELEASE RECORDS *FROM* (PRACTICE NAME) _____

PHONE: _____ FAX: _____

SEND RECORDS *TO* (PRACTICE NAME) _____

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 ____ FNA results _____

Bone age report ____ DXA report ____ Ultrasound report ___ Other_____

Treatment Dates 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, HIV, AIDS, behavioral or mental health services or alcohol abuse.

My signature is required to calidate 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:_____

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