

CREEDMOOR CENTRE ENDOCRINOLOGY

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RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ **DOB:** _____

I authorize Creedmoor Centre Endocrinology to release my medical records to the following Organization or Physician.

I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral, mental health service, drug abuse, or alcohol abuse.

Name of Organization or Individual: _____

Address: _____

Phone Number: _____

Fax Number: _____

Records Requested: _____

I understand use of disclosure of information identified above is voluntary

Print Name: _____ **Date:** _____

Signature: _____

Witness: _____ **Date:** _____