



# 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: \_\_\_\_\_