Creedmoor Centre Endocrinology
Julia Warren-Ulanch M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Date of Birth:** _____ **Date**:_____

The undersigned hereby acknowledges that a copy of the HIPPA laws and guidelines has been provided to them by Creedmoor Centre Endocrinology.

I authorize Creedmoor Endocrinology's staff to leave medical, appointment and/or account information pertaining to my care by the following methods. This authorization expires one year from the date signed. **I will assume the responsibility to notify them of any changes in this information.**

If we are unable to reach you, are there any relatives or friends with whom you authorize our office to discuss your health information? Please list name(s), relationship(s), and their phone number(s) below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

List of Providers for Medical Release of Information

I, (Patient or Guardian)_____hereby authorize:

Creedmoor Centre Endocrinology
8341 Bandford Way Ste. 103
Raleigh, NC 27615
Phone: 919-845-3332 Fax: 919-845-3395

To release and forward my medical records, including machine readable medical and demographic data to the following providers:

First & Last Name Provider	Medical Specialty	Practice Name	Office Phone #
	General Practioner/ Primary Care Doctor		