

RALEIGH ENDOCRINE ASSOCIATES

ENDOCRINOLOGY DIABETES & METABOLISM

Authorization to Request Medical Information

I, _____ DOB: _____ hereby authorize:

Name of Provider and/or Facility _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

To release and forward my medical records, including demographic data to:

DENIS I. BECKER, M.D., F.A.C.E. ELIZABETH H. HOLT, M.D., F.A.C.E.

COREY D. BERLIN, M.D. GLENN M. STALL, M.D. SHAWNEE D. WEIR, M.D., F.A.C.E.

ANGELA GLASS, M.S.N., F.N.P.-C., WILBUR BARDON, P.A.-C JENNIFER BRIDGER, P.A.-C

Patient Name: _____

Date of Birth: _____ SS#: _____ (optional)

Address: _____

Phone: (_____) _____ Fax: (_____) _____

Dates of service you would like released: _____

The information release may include the following:

Clinic Notes Labs/Pathology X-Ray Reports ER Hospitalizations

Operative/Procedure Notes History/Physicals Urgent Care HIV/AIDS

Social Services Disability Discharge Summary's Mental Health/Drugs/Alcohol

Ultrasound Bone Density Dietician Notes _____

I understand that this authorization can be revoked at any time and that it does expire one year from the signature date.

Signature of Patient or Legal Guardian

Relationship to Patient

Print name of Patient or Legal Guardian

Date