Carolina Elite
WOMEN'S CARE
OBSTETRICS | GYNECOLOGY

Carolina Elite Women's Care P.A.
Elite Care for the Elite You

AUTHORIZATION TO RELEASE / SEND MEDICAL RECORDS

Patient's Name: _____ Chart#: _____
Patient's Address: _____ Date of Birth: ____/____/____
_____

PROVIDER / FACILITY BEING ASKED FOR INFORMATION:
Provider / Facility Name: _____
Provider / Facility Address: _____
Phone Number & Fax: **(Ph)** **(Fax)** _____

**ATTENTION* Your Provider/Facility may charge you a fee for sending copies of your records to our office.*

I request and authorize the above named provider/facility to release the following health information concerning me to the following practice:

Carolina Elite Women's Care
901 US-70 Suite 100
Garner NC 27529

◯ Send only my records from this (Date) _____/_____/_____ to this (Date) _____/_____/_____

◯ Send ONLY the following specified records: _____
_____

This purpose of releasing this data shall be:
◯ continued medical treatment ◯ personal ◯ second opinion
◯ other reason: _____
◯ complete transfer of care / Reason for Transfer of Care: _____

I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. This consent will automatically expire after 90 days from the date on which it is signed.

Patient Signature: _____ **Date Signed: / / .**

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carolinaelitewomen.com