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

## AUTHORIZATION TO RELEASE MY RECORDS

**I authorize Carolina Elite Women's Care to release my medical records as noted below:**

Patient's Full Name: ________________________________________

Patient's DOB: _____/_____/_____

Patient's Address: ________________________________________

________________________________________

________________________________________

Patient's Phone#: (_____) ____________________

**SEND MY RECORDS TO:** ________________________________________

________________________________________

________________________________________

**Fax#: (_____)________________**

**Phone#: (_____)________________**

Information to be Released:

☐ Entire Chart ☐ Other: ________________________________________

☐ Office Notes ☐ Operative Notes ☐ Labs ☐ Ultrasound Reports

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

**Patient's Signature: ________________________________________ Date: ____/____/____**

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