Carolina Oncology Specialists, PA

PO Box 3710 * 2406 Century Place SE * Hickory, NC 28603
(828) 324- 9550 * Fax (828) 324- 4154

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release medical information to include history, physical, pathology reports, and radiological reports on:

Name:_____ **DOB:**_____

Please send information from: _____

_____

_____

_____

Please send to our office by fax: (828) 324- 4154

*The intent of requesting these medical records is for my treatment. I understand I may revoke authorization by a written request and also understand that this information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.

Patient□ s Signature:_____

Date: _____

*This authorization expires only if revoked by person signing.