

CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name _____

Patient's Address _____

Patient's Date of Birth _____

Patients's Social Security Number _____

TO: _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

- SEND ALL OF MY RECORDS
- SEND RECORDS FROM (DATE) _____ TO (DATE) _____
- SEND MY RECORDS PERTAINING TO _____

____ Change of PCP ____ Continued Care

SEND RECORDS TO:
____ Vijay K. Juneja, MD ____ Prashant K. Patel, MD ____ Amrita S. Parikh, MD

Cary Internal Medicine & (P) 919-467-6125 (F) 919-467-1728
The Diabetes Center
103 Baines Court Suite 200
Cary, NC 27511

Patient's Signature

Date

Witness