AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

PATIENT INFORMATION (please print)

Name:_____DOB:_____

Social Security Number:_____

Address:_____City/State/Zip:_____

Telephone Number:_____

RELEASE MY MEDICAL RECORDS TO:

Dare Direct Primary Care
PO Box 695
Nags Head, NC 27959
Fax: 252-715-1991 Phone:252-715-5315

FROM:

_____

_____

_____

_____

I hereby give_____ permission to transfer my complete medical records, including but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests to be housed permanently at Dare Direct Primary Care, PLLC. Any further transfer of records can be made by written request.

BY MY SIGNATURE I AUTHORIZE THE TRANSFER OF MEDICAL RECORDS

PATIENT:_____ DATE:_____