AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO REED FAMILY MEDICINE

Patient's Full Name_____ Date of Birth_____

Street Address _____

City, State, Zip_____

I hereby authorize _____
(office we are requesting information from) to release my entire medical record for transfer of care.

PLEASE FAX RECORDS TO: 442-200-2368

I hereby authorize disclosure of the health information as indicated on this form. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it is will not affect any information released prior to notification of cancellation.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Date**

Melissa Reed, MD
REED FAMILY MEDICINE
8341 Bandford Way, #103
Raleigh, NC 27615
P 919-578-5525
F 442-200-2368