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CONSENT FOR RELEASE OF MEDICAL RECORDS

I, _____, do hereby consent to and authorize
 _____ to disclose to
 _____ at (address) _____
 _____ information in my medical records,
 including current and previous medical records from other practices and practitioners, hospitals,
 and/or clinics, which are part of my medical records.

My Date of Birth is _____
 My Social Security Number is _____
 This information is strictly for purposes if identification.

 Patient's Signature

 Date

If additional consent (other than the patient's) is necessary from a person authorized to give consent
 (such as parent, guardian, etc.)

 Signature

 Date

 Relationship to Patient

 Date

- 201 Queens Road, Charlotte, NC 28204 • (704) 372-5180 • Fax (704) 376-6280
- 101 W. T. Harris Blvd. East, Suite 5201, Charlotte, NC 28262 • (704) 547-1495 • Fax (704) 547-1861
- 1450 Matthews Township Pkwy., Suite 350, Matthews, NC 28105 • (704) 841-8877 • Fax (704) 841-8188
- 10650 Park Road, Suite 320, Charlotte, NC 28210 • (704) 541-8207 • Fax (704) 540-8288
- 16455 Statesville Road, Suite 420, Huntersville, NC 28078 • (704) 892-2949 • Fax (704) 892-2946
- 1518 E. Third Street, Suite 150, Charlotte, NC 28204 • (704) 370-2076 • Fax (704) 370-2079
- 1085 Northeast Gateway Ct., N.E., Suite 180, Concord, NC 28025 • (704) 707-2200 • Fax (704) 707-2203
- 15825 John J Delaney Drive, Suite 260, Charlotte, NC 28277 • (704) 334-4824 • Fax (704) 941-3287
- 1718 East 4th Street, Suite 807, Charlotte, NC 28204 • (704) 375-5755 • Fax (704) 335-3380