

CAROLINA CONCEPTIONS, PA

Grace Couchman, MD
William Meyer, MD

2601 Lake Drive, Suite 301
Raleigh, NC 27607
(919) 782-5911 Office
(919) 861-6419 FAX

Consent to Release Medical Records

Date: ____/____/____ Medical Records #: _____

Patient: _____ Date of Birth: ____/____/____

(please print clearly)

Social Security #: _____-_____-_____

From : Carolina Conceptions -- Medical Records

Please Indicate the Address to which you would like your records sent.

Name: _____

(please print clearly)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Reason for Release: _____

_____ Send my entire medical records (\$45 administrative fee not covered by insurance)

_____ Send my medical records related to current pregnancy to OB for continuation of care (N/C)

_____ Send pathology reports ONLY (N/C)

_____ Send records from date: _____ to date: _____

This release includes all protected health information and shall remain in effect for 180 days, unless written authorization is received requesting otherwise. Please allow up to 2 weeks for records to be sent.

Patient Signature: _____