Carolina Oncology Specialists

A Partner of OneOncology

Patient Name: _____

Date of Birth: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release medical information to include history, physical, pathology reports and radiological reports.

Please send information from:

_____

_____

_____

_____

_____

Please send to our office by fax at the following number:

828.324.4154

- **The intent of requesting these medical records is for my treatment. I understand I may revoke authorization by written request. I also understand the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.**

Patient Signature: _____ Date: _____

- **This authorization expires only if, and when revoked by person signing.**

CAROLINA ONCOLOGY SPECIALISTS, PA *2406 Century Place SE, Hickory, NC 28602*