Coastal Reproductive Endocrinology and Infertility Center
Coastal AHEC

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

YOUR NAME: ____
First Middle Maiden/former Last

BIRTH DATE: ______________SOCIAL SECURITY NUMBER:_______________

To: Dr.____

I authorize and direct you to release my medical records/medical information from __________ to ___________ to: Dr. Mark Pasquarette, MD and Julie Ramsey, NP - for the purpose of continuity of medical care.

Please send my records or fax them to:

Coastal Reproductive Endocrinology and Infertility Center
Women's Health Specialties, North
2221 S. 17th Street
Wilmington, North Carolina, 28403

Fax Number: 910-815-0840 Phone Number: 910-815-5190

I understand that I may revoke this consent at any time and that this consent will automatically expire 90 days from the date signed below. This hereby releases the sender from all legal responsibility or liability which may result from the release of my medical records.

Date: _________________

Signature: ____
(you or authorized representative)

Witness: ____________________________ Relationship: ______________________

Winword/forms/nprelease202