CAROLINA SURGERY & CANCER CENTER, PLLC

advanced personal care close to home

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name:_____ Date of Birth:_____

Address:_____

City, State, Zip Code:_____

_____

I hearby authorize:

Carolina Surgery and Cancer Center
1501 Tate Blvd. SE, Suite 202
Hickory, NC 28602
Phone: (828) 485-2707
Fax: (828) 485-2708

To disclose information from my/my minor child's medical record to:

Name of Practice:_____

Address:_____

City, State, Zip Code:_____

This information is needed for the following reason:

_____

The specific information I need to have released is:

_____

_____

_____

_____ _____

Signature: (Parent or Legal Guardian of Minor Child) Date