Cary Rheumatology & Arthritis Associates PA
1720 NW Maynard Road Cary ,NC 27513
919-344-0180 (P) 919-851-1900 (F)

Authorization to Provide Medical Information

Patient Name _____ Gender ☐Male ☐Female D.O.B_____

Address_____ City_____ Zip Code_____

Day Time Telephone_____ ☐Home ☐Work ☐Cell

Allow

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(Participant of P2POpen Network: www.JoinTheNetwork.com)

To disclose the following medical information:

☐ Any and All Records ☐ Hospital Records ☐ Medications ☐ Immunizations ☐ Progress/Clinic Notes ☐ Radiology Results/CD ☐ Lab Results

☐ Other Records

(specify):_____

I voluntarily consent to authorize, my physician and/or its administrative and clinical staff to share my health information with the following facility or health care provider:

Provider_____Practice Name_____

Address:_____

Phone:_____

Fax:_____

For the Purpose of: ☐ Continuing Medical Care ☐ Transfer of Care ☐ Personal ☐Other:___

Signature _____ Date_____

Print Name _____

Patient/Legal Guardian_____