Carolina Gynecology
700 Exposition Place
Suite 161
Raleigh, NC 27615
Dr Andrea Torsone

RECORDS RELEASE AUTHORIZATION

TO: _____
DOCTOR OR HOSPITAL

FAX: _____

_____
ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MEDICAL RECORDS TO:

Carolina Gynecology
700 Exposition Place
Suite 161
Raleigh, NC 27615
Phone: 919-846-6962 Fax: 919-841-0239

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM _____TO _____

NAME _____ DATE_____

DOB _____ SSN _____

ADDRESS _____

SIGNATURE _____

WITNESS _____
(IF RELATIVE, STATE RELATIONSHIP)