NORTH RALEIGH ENDOCRINOLOGY
Alvi Prime Time Clinics PLLC
11009 Ingleside Place, Suite 204, RALEIGH, NC 27616
PHONE: 919-844-6218 FAX: 919-847-5699

Information Release Authorization

Physicians Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

I hereby consent to the release and disclosure of my personal health information to:

NORTH RALEIGH ENDOCRINOLOGY
11009 Ingleside Place, Suite 204, RALEIGH, NC 27616
PHONE: 919-844-6218 FAX: 919-847-5699

For the following purpose: □ Referral □ Physician Change □ Second Opinion

Other: _____

This release authorization includes my personal health information consisting of the following:

□ All Records □ Information for date of service _____ □ Diagnosis _____

Other: _____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within thirty (30) business days of North Raleigh Endocrinology having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____

Patient Name

_____

Signature **Date of Birth** **Date**