AUTHORIZATION TO OBTAIN INFORMATION

Patient Name: Date of Birth:

I hereby authorize Elizabeth Dewey, MD, at 3150 N. Elm St., Suite 200, Greensboro NC 27408. fax 336-450-1560.

to obtain my medical records

_____ entire record _____ immunizations _____ imaging studies

from the following

Dr. Name or Practice Name:

Phone #:

Address:

The records are required for the specific purpose of continuity of care.

I understand that my authorization will remain effective from the date of my signature until 90 days, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

_____

Signature of Patient or Designated Representative Date