

Carolina Women's Health  
Dr. J. Stewart Carr, MD  
3404 Wake Forest Rd., Suite 200  
Raleigh, NC 27609  
(919)235-0097 phone

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

\_\_\_\_\_  
(Patient Name)

\_\_\_\_\_  
Date of Birth (Mo/Dy/Yr)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
Phone (work)

\_\_\_\_\_  
(City, St, Zip)

\_\_\_\_\_  
Phone (home)

\_\_\_\_\_  
(Medical Record Number)

\_\_\_\_\_  
(Social Security Number)

I, \_\_\_\_\_, do hereby authorize \_\_\_\_\_  
to release the following:

All records     Labs only     Progress Notes     Operative Notes     Other

To: **Carolina Women's Health**  
**Dr. J. Stewart Carr, MD**  
3404 Wake Forest Rd., Suite 200  
Raleigh, NC 27609  
(919)235-0097 phone  
(919)235-0098 fax

Is this a permanent transfer? (Circle One) YES / NO Reason for request: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date