



Release of Information to Carolina Regional Radiology

TELEPHONE: (919) 331-2001
FAX: (919) 331-2003

PLEASE PRINT:

Name: _____

Date of Birth: _____

Social Security Number: _____

Name of Hospital or Clinic: _____

Address: _____

I hereby authorize the release of _____
films and/or medical records regarding the continuity of care to Carolina Regional
Radiology.

Please mail films and reports to:

**Carolina Regional Radiology
PO Box 193
169 Rawls Road
Angier, NC 27501**

Patient's Signature

Date

Witness

Date