

# Raleigh OB-GYN Centre, PA

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## AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I authorize Raleigh OB/GYN Centre to obtain my medical records as indicated below.

\_\_\_\_\_ Medical Records from year \_\_\_\_\_ to present.  
or  
\_\_\_\_\_ Records pertaining to \_\_\_\_\_  
(medical problem or specific dates of treatment)

\_\_\_I do \_\_\_I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and /or psychological assessment, and treatment for alcohol and/or drug abuse.

This information is to be obtained from: \_\_\_\_\_

### PURPOSE OF DISCLOSURE:

___ Continuation of Care	_____ (Name of Physician or Facility) Required information
___ Change of Doctor	_____
___ Disability Determination	_____ (Street Address & Suite #) Required information
___ Insurance	_____
___ Legal Investigation	_____
___ Personal	_____ (City, State & Zip) Required information
___ Referral to Specialist	_____
___ Worker Comp	_____
___ Other _____	_____ (Phone # / Fax #) Required information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)  
\_\_\_\_\_ SSN #: \_\_\_\_\_  
(Current Address) \_\_\_\_\_  
\_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (If a minor) \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Expiration date of consent \_\_\_\_\_