



*advanced personal care close to home*

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_

I hereby authorize:

**Carolina Surgery and Cancer Center**  
**1501 Tate Blvd. SE, Suite 202**  
**Hickory, NC 28602**  
**Phone: (828) 485-2707**  
**Fax: (828) 485-2708**

To disclose information from my/my minor child's medical record to:

Name of Practice: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

This information is needed for the following reason:

\_\_\_\_\_

The specific information I need to have released is:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature: ( Parent or Legal Guardian of Minor Child)

\_\_\_\_\_  
Date