CONSULTS IN HYPERTENSION
1213 Culbreth Drive, Suite 225
Wilmington, NC 28405

Margaret B. Collins, M.D., F.A.S.H.

AUTHORIZATION FOR EXCHANGE OF MEDICAL INFORMATION

I, (your name)_____, grant permission to Consults in Hypertension, P.A. and Margaret B. Collins, M.D. to release, forward, and request my medical records, including machine readable medical and demographic data, to and from the following recipient(s):

Provider Name Practice/Organization Name Phone

_____

_____

_____

_____

Reason for release of records: _____

Patient Name_____Date of Birth_____

Patient Address_____

_____

Phone ( )_____Email _____

Treatment Dates (if applicable): _____

Information to be released (cross out any you do not wish included)

Clinic Notes Laboratory Studies Radiology Studies Ambulatory BP Monitoring

Other _____

I understand this agreement can be revoked at any time, and will expire one year from today. I also understand it is my responsibility to keep information current.

Patient Signature_____Date_____

Guardian Signature (if applies)_____Date_____