



Richard Krumdieck, MD David Eagle, MD Timothy Kuo, MD

REGARDING PATIENT:

_____	_____	_____
Last Name	First Name	MI

Street Address		

_____	_____	_____
City	State	Zip Code

_____	_____	
Date of Birth	Social Security Number	

INFORMATION FROM:

Name (Healthcare Provider)		

Street Address		

City, State, Zip Code		

INFORMATION RELEASED TO:

Lake Norman Oncology
170 Medical Park Road, Suite 101
Mooresville, NC 28117
Phone (704)799-3946 Fax (704)799-3956

This information shall include the following:

- | | |
|--|---|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> ECG/EEG | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Other (Specify) _____ | |

NOTICE: This authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of visits, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted diseases, including HIV/AIDS information. Such records will be disclosed unless specified. Information to exclude is listed below:

Exclusions: _____

Signature of Patient/legal authority: _____