

**K. Jean Lucas, MD**  
**Kristin Gainey Ferree, FNP**

**Diabetes & Endocrinology Consultants, PC**

611 N 35<sup>TH</sup> ST  
Morehead City, NC 28557-3126

**CONSENT FOR RELEASE OF MEDICAL RECORDS**

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ SS#: \_\_\_\_\_

**REQUEST RECORDS FROM:**

**K. Jean Lucas, MD**  
**Diabetes & Endocrinology Consultants, PC**  
**611 N 35<sup>th</sup> St**  
**Morehead City, NC 28557-3126**

I do hereby consent and authorize you to release copies of my medical records to the medical office listed below. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, and any information relating to HIV testing, AIDS, and any AIDS-related syndromes. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below. This authorization is valid for this signed request only.

**SEND RECORDS TO:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Fax \_\_\_\_\_

**SPECIFIC RECORDS REQUEST:**

- |                         |                         |
|-------------------------|-------------------------|
| _____ All Records       | _____ Pathology Reports |
| _____ Admission Note    | _____ Lab Results       |
| _____ Discharge Summary | _____ Office Notes      |
| _____ Operative Note    | _____ Radiology Reports |
| _____ Other:            |                         |

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