Carolina Spine Center

Phone: 910-997-3733 | Fax: 910-997-3703

Authorization For the Release of Medical Records

First Name: ________________________ MI: ______ Last Name: ____________________________

Date of Birth: _____/_____/_________ Phone #: ______-______-__________

Address: _____________________ City: _______________________ St: ______ Zip: ____________

I hereby request that my medical records, as indicated below, be released to Carolina Spine Center for the continuation of patient care:

Persons/Organization providing information: ____

To : Carolina Spine Center

Attn: [ ] Paul Singh M.D. [ ] Neema Patel FNP

[ ] Louis Torres M.D. [ ] All Providers

Address : 100 Parkway Office Court, Suite 108, Cary NC 27518

Phone: 910-997-3733

Fax: 910-997-3707

- Office Notes
- Operative Notes
- Consultation Reports
- Laboratory Test Results
- Images and Imaging Reports

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

☐ I authorize the release of the above indicated medical information to Carolina Spine Center

Name: _________________________ Signature: _______________________ Date: __________