

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 : 809 S. Long Drive, Suite G. Rockingham, NC 28379

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: _____