

2304 Wesvill Court, Suite 320
Raleigh, NC 27607
T 919-825-3902
F 919-825-3910



1303 Carthage Street
Sanford, NC 27330
T 919-292-2468
F 919-292-2167

Request for Medical Records to be Sent to Spine & Pain Associates, PLLC

Date: _____ Medical Record Number (to be filled in by practice): _____

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____

Cell: _____ Email: _____

I, (Name) _____, **hereby authorize**
_____ **to release the following information:**

- | | |
|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Consultation Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Office Visits |
| <input type="checkbox"/> Hospital Records | <input type="checkbox"/> Procedure Notes |
| <input type="checkbox"/> Emergency Department Records | <input type="checkbox"/> Surgery/Operative Reports |
| <input type="checkbox"/> Pathology/Lab Reports | <input type="checkbox"/> Radiology Reports (Ultrasounds, X-rays, MRI, CT scans) |

Dates of Service for Requested Release:

- All Dates
 Date Range: _____ to _____

I do do not authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Release information to: Spine & Pain Associates, PLLC
2304 Wesvill Court, Suite 320
Raleigh, NC 27607
T 919-825-3902 | F 919-825-3910 | www.spineandpainassociates.com

Patient Name: _____ Date: _____

Signature: _____