

Authorization for Release of Medical Records
Atlantic Neurosurgical & Spine Specialists, P.A.

2208 S. 17th St, Wilmington, NC 28401
 Phone: 910-763-3333 Fax: 910-763-3336

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Social Security Number
Address	City	Zip	Phone
RELEASE FROM: [Name of physician or facility releasing information]			

I authorize release of my medical records from:

Physician/Facility			
Address	City	Zip	Phone: Fax:
RELEASE TO: [Name of physician or facility receiving information]			

Please send my medical records to:

Physician/Facility Atlantic Neurosurgical & Spine Specialists, PA			
Address 2208 S. 17th St.	City Wilmington, NC	Zip 28401	Phone :910-763-3333 Fax: 910-763-3336

RELEASE INFORMATION			
Reason: <input type="checkbox"/> Change of insurance	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Personal file	
<input type="checkbox"/> Moving out of area	<input checked="" type="checkbox"/> Specialist consultation	<input type="checkbox"/> Legal	

Please release the following (check all that apply)

RECENT H&P	X	LAST THREE VISITS	X
LAB REPORTS	X	X-RAY REPORTS	X
HOSPITAL REPORTS	X		

- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test results.	YES	NO	Initials

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Note: This consent is valid for one year (365 days) after date of request. This consent may be revoked, in writing, by the signer at any time.