# 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

| 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<br>**Atlantic Neurosurgical & Spine Specialists, PA** | | | |
|---|---|---|---|
| Address<br>**2208 S. 17th St.** | City<br>**Wilmington, NC** | Zip<br>**28401** | Phone<br>**910-763-3333** |

RELEASE TO: [Name of physician or facility receiving information]

Please send my medical record to:

| Physician/Facility | | | |
|---|---|---|---|
| Address | City | Zip | Phone/Fax |

RELEASE INFORMATION

Reason:[ ] Change of insurance [ ] Transfer of care [ ] Personal file
[ ] Moving out of area [ ] Specialist consultation [ ] Legal

Please release the following (check all that apply)

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

- Please allow 15 days for processing.
- 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.

| | YES | NO | Initials |
|---|---|---|---|
| I authorize the release of HIV/HTLV/AIDS test results. | | | |
| I understand that I may be charged for copies provided. | | | |

| | |
|---|---|
| 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.