MEDICAL RECORDS RELEASE FORM

Patient Name:_____

Date of Birth:_____ Phone Number:_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initialing this form, I am specifically authorizing that release of this information.

Initials: _____ Date: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

Restore Spine and Pain
1505 Werrington Drive
Holly Springs, NC 27540
Phone: (984) 444-8824 |Fax: (984) 202-2882
documents@restorespineandpain.com
www.restorespineandpain.com

I do give permission for these records to be faxed and/or emailed to the above entity.

Please forward:

☐ Office Visits ☐ Initial History and Physical ☐ Imaging Reports

☐ Lab Reports ☐ Correspondence ☐ Insurance Information

Other (please specify):_____

Patient Signature: _____ Date:_____