Carolina Orthopaedic
& Sports Medicine Center
Focused on You

Medical Records Release from Carolina Orthopaedic & Sports Medicine Center

Full Name of Patient: ______________________________

Birth Date: ________________ Social Security #: ________________

I authorize and request Carolina Orthopaedic & Sports Medicine Center to release medical records and/or X-rays to:

Name: ______________________________

Fax # or Mailing Address: ______________________________

Phone #: ______________________________

The complete history of records in your possession concerning my illness and/or treatment during the period from: ________________ to ________________

This authorization expires on: ______________________________

Patient's Signature: ______________________________

(If relative or guardian, state relationship.)

Patient's Address: ______________________________

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Home Phone #: ______________________________

Work #: ______________________________

Witness: ______________________________

Date: ______________________________

Payment Received on ________________ for $ ________________ Cash or Check #: ________

2345 Court Drive • Gastonia, NC 28054

Phone: 704-865-0077 • Fax: 704-867-6401

www.CarolinaOrthopaedic.com

Carolina Orthopaedic & Sports Medicine Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.