Carolina Orthopaedic & Sports Medicine Center

Focused on You

Medical Records Release to Carolina Orthopaedic & Sports Medicine Center

Full Name of Patient: _____

Birth Date: _____ Social Security #: _____

I authorize and request _____

to release medical records and/or X-rays to:

Carolina Orthopaedic & Sports Medicine Center
2345 Court Drive
Gastonia, NC 28054

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: _____

_____

_____

Home Phone #: _____

Work #: _____

Witness: _____

Date: _____

2345 Court Drive • Gastonia, NC 28054
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www.CarolinaOrthopaedic.com