CAROLINA NeuroSurgery & Spine ASSOCIATES

AUTHORIZATION TO RELEASE OR REQUEST PROTECTED HEALTH INFORMATION

I, (full name of patient)_____DOB_____

Contact # _____Mailing Address _____

hereby authorize:

Carolina Neurosurgery & Spine Associates (CNSA)
Phone 704-376-1605 Fax 704-335-8448

To:☐ **RELEASE** information from my medical record **TO** **OR** To:☐ **REQUEST** information **FROM**

(**LIST AUTHORIZED ENTITY BELOW**)

Provider/Organization/Individual_____

Address:_____

Phone:_____Fax:_____

IMPORTANT NOICE: This is a FULL release, including drug, alcohol, psychiatric and sexually transmitted disease information UNLESS listed here:

Treatment Dates (Specify Date or Date Range): _____

☐ Entire record ☐ Medication list ☐ Other (please specify below)

☐ History & Physicals ☐ Imaging Reports _____

☐ Office visit notes ☐ Hospital notes ☐ Films on CD (Acquire through Imaging Department)

Purpose of Release: ☐ Legal ☐ Changing physicians ☐ Insurance ☐ Personal use ☐ Disability

☐ Workers' Compensation ☐ Other:_____(Please describe)

*** THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE BELOW UNLESS AN EXPIRATION DATE IS INDICATED HERE: ____/____/_____**

Your records may include records or partial records from other providers; however CNSA is not responsible for the completeness or accuracy of those records. We provide them merely as a convenience to you. You are responsible for obtaining those records directly.

NOTICE TO PATIENTS: The patient or the patient's representative may inspect and/or copy the health information disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at any time. **A copy of this authorization will be made available to you upon your request**. Your treatment and/or billing is not conditional on this authorization being signed except in the specific circumstances allowed by the HIPAA Privacy Rule. We cannot protect against the possibility that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by law.

_____ _____ _____

Signature of Patient/Parent/Legal Guardian/Authorized Person Date Relation to Patient

PLEASE READ: A fee may be charged to make copies of the requested medical record. We contract with DataFile Technologies to provide medical records requested from our office. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.