

Medical Records Release
(to be completed in full at time of submission)

Patient: _____ Date Of Birth: _____

SSN: _____ Which doctor? _____

By signing below I acknowledge that Carolina Neurosurgery, P.A., has my permission to release my medical records. Carolina Neurosurgery, P.A. is released from any and all laws related to the disclosure of confidential or privileged information. I understand that the average length of time needed to prepare these copies is 7-10 business days. If it has been longer than 2 years since I was last seen, I understand that my records are in an off-site storage facility, and that an additional two weeks must be allowed. I understand that ONE set of my records will be made available to me or another medical provider at no charge. Additional sets of records must be paid for prior to their release. **Fees are due and must be paid when this request is made.**

CHOOSE ONE OPTION:

_____ I will pick up my records. Call me at _____ when they are ready.
Messages may be left on voice mail or answering machines.

_____ Fax my records to this fax #: _____
I understand that ONE attempt will be made to fax records; if they aren't received, I will pick them up or ask to have them mailed. It is my responsibility to follow up to see if records have been received.

_____ Mail my records to this name and address: _____

Signed: _____ Date: _____
(patient or parent/guardian of minor)

.....
(to be completed by staff)

Records request accepted by: _____ On: _____

Fees paid with request?: No Charge Attorneys/Insurance Companies: \$10

Records copied by: _____ On: _____

To be picked up? Yes Patient notified on: _____ that they are ready.

Faxed? Mailed? (circle one) On : _____