Carolina Spine and Disc Center
11618 Hwy 70 W, Suite 100
Clayton, NC 27520
Phone: 919-373-2000
Fax: 919-373-2200

CAROLINA SPINE & DISC CENTER

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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name(s): : _____ Social Security # (last 4 digits): _____

I request and authorize _____

to release healthcare information of the patient named above to:

Name: **Carolina Spine and Disc Center**

Address: **11618 Hwy 70 W, Suite 100**

City: **Clayton** **State: NC** **Zip: 27520**

This request and authorization applies to:

- Healthcare information, Office notes, Reports and Radiography results related to:
  - ☐ Lumbar (Low back/Hip/Leg) pain or problem.
  - ☐ Cervical (Neck/Shoulder/Arm) pain or problem.
  - ☐ Other: _____

**Please fax records to 919-373-2200**

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.