



## Neuroscience & Spine Center of the Carolinas, LLP

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### Request for Release of Medical Records and Notice of Privacy Practices

1. I hereby authorize \_\_\_\_\_

\_\_\_\_\_

to release a copy of my medical records to Neuroscience & Spine Center of the Carolinas.

2. I also hereby authorize Neuroscience & Spine Center of the Carolinas to release a copy of my medical records to \_\_\_\_\_

I understand that this authorization allows the release of all information in my medical records, including information regarding a chemical dependency problem or treatment of mental conditions, STD, HIV, TB, MRSA, or any other information deemed necessary for other healthcare providers.

With the exception of: \_\_\_\_\_

3. I have read and understand the Notice of Privacy Practices which became effective April 14, 2003. I understand that at any time I may request a copy of this notice which has been provided to me.

- Yes, I would like a copy.  
 No, I do not wish to have a copy at this time.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date of Birth \_\_\_\_\_

Witness \_\_\_\_\_