Carolina Spine & Neurosurgery Center
An Affiliate of Mission Health
7 Vanderbilt Park Dr ● Asheville, N.C. 28803 ● (828) 255-7776

Patient Acct # ______________

Expiration Date ______________

*** Bolded areas are required to avoid delay**

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize Carolina Spine & Neurosurgery Center to **SEND/RECEIVE** information from the medical record of: (*Please circle one*)

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Address: ______________________________
Street City & State Zip code

Home #: ______________ **Social Security #:** ______________

These records will be **SENT TO / RECEIVED FROM:** (*Please circle one*) **Fax #:** ______________

Name of Person or Facility: ______________________________ **Phone #:** ______________

Address: ______________________________
Street City & State Zip code

Records sent by: MAIL PATIENT TO PICK-UP FAX (ONLY TO OTHER MEDICAL FACILITIES)

INFORMATION TO BE RELEASED (PLEASE CHECK INFORMATION REQUIRED):

☐	ALL OFFICE NOTES ***Please note that if you have been seen for multiple problems, all records will be sent unless you specify differently**
☐	OFFICE NOTES ONLY
☐	HOSPITAL NOTES ONLY
☐	PHYSICAL THERAPY NOTES ONLY
☐	LABORATORY NOTES ONLY
☐	PATHOLOGY NOTES ONLY
☐	EMG / NCV NOTES ONLY
☐	RADIOLOGY REPORT ONLY
☐	RADIOLOGY REPORT W/ FILM ONLY
☐	MRI REPORT ONLY
☐	MRI REPORT W/ FILM ONLY

OTHER: ______________________________

THIS INFORMATION WILL BE INCLUDED UNLESS NOTED NOT TO SEND:

☐	BEHAVIORAL HEALTH/PSYCHIATRIC CARE	☐	HUMAN IMMUNODEFIECIENCY VIRUS (HIV)
☐	ACQUIRED IMMUNODEFICIENCY SYNDROME	☐	TREATMENT FOR ALCOHOL/DRUG ABUSE

PURPOSE OF DISCLOSURE:

☐	WORKER'S COMPENSATION	☐	CONTINUED PATIENT CARE	☐	COMMERCIAL INSURANCE
☐	PERSONAL USE	☐	OTHER:		

I understand the information released is for the specific purpose above and may not be provided in whole or part to any other agency, organization, or person. I understand records from other health care providers will not be released. I may revoke this authorization in writing at any time. I understand that Carolina Spine & Neurosurgery Center has thirty (30) days from the date of my revocation in their system. This authorization expires one (1) year from the date of my signature. In reference to any mental health information contained in the medical records, I hereby waive my/the patient's right to privileges of confidentiality. Carolina Spine & Neurosurgery Center may impose a fee to cover the cost of labor, copying, postage and preparing a summary of the requested information. Carolina Spine & Neurosurgery Center will act on this request within thirty (30) days of receipt or within sixty (60) days if the requested information is not maintained or accessible to Carolina Spine & Neurosurgery Center on-site.

NOTE: PATIENTS REQUESTING MEDICAL RECORDS WILL BE CHARGED FOR COPIES.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee to copy ($10.00 minimum) is $0.75 per page for the first 25 pages, $0.50 per page for additional pages up to 100, and $0.25 for each additional page in excess of 100. No fee shall be charged for reproducing and forwarding records directly to other physicians. Please allow a minimum 2-4 weeks for records to be copied. We will prioritze emergency requests when possible.

______________________________ ______________________________

Signature of Patient or Legal Representative **Date** **Relationship to Patient**