Carolina Center *for* Restorative Medicine

Restoring Hope and Health with Heart

Request for Medical Records to be Sent to Carolina Center for Restorative Medicine

809 Spring Forest Road, Suite 100
Raleigh, NC 27609
www.ccrmraleigh.com
info@ccrmraleigh.com
P 919-803-4268 | F 919-977-1381

Date: _____ Medical Record Number: (to be filled in by practice): _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

Email Address: _____

I, (NAME) _____, hereby authorize _____ to release the following information:

- ◯ All Records
- ◯ Consultation Notes
- ◯ Discharge Summary
- ◯ Emergency Department Records
- ◯ Hospital Records
- ◯ Office Visits
- ◯ Pathology Lab Reports
- ◯ Radiology Reports (ultrasounds, x-rays, MRI, CT scans)
- ◯ Surgery/Operative Reports

Dates of service for requested release:

- ◯ All dates
- ◯ Date Range _____ to _____

I ◯ do ◯ do not authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Release information to: Carolina Center for Restorative Medicine
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Patient Signature: _____ Date:_____

Printed Name: _____