



Medical Records Release from COSMC

Full Name of Patient: _____

Date of Birth: _____ Social Security #: _____

I authorize and request Carolina Orthopaedic & Sports Medicine Center, P.A. to release medical records and/or x-rays to:

Name: _____

Fax # or Mailing Address: _____

Phone #: _____

The complete history of records in your possession, concerning my illness and/or treatment during the period from: _____ to _____.

This authorization expires on: _____.

Patient's Signature: _____
(If relative or guardian, state relationship)

Patient's Address: _____

Home Phone #: _____

Work #: _____

Witness: _____

Date: _____

Payment Received on _____ for \$_____ Cash or Check #: _____

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