



Medical Records Release to COSMC

Full Name of Patient: _____

Date of Birth: _____ Social Security #: _____

I authorize and request _____ to release medical records and/or x-rays to:

**Carolina Orthopaedic & Sports Medicine Center, P.A.
620 Summit Crossing Place, Suite 108
Gastonia, NC 28054**

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: _____

**620 SUMMIT CROSSING PLACE, SUITE 108 • GASTONIA, NC 28054
Phone: 704/865-0077 • Fax: 704/867-6401
www.CarolinaOrthopaedic.com**