MEDICAL RECORDS REQUEST

Name: _____ Date of Birth: _____

I, the under signer, hereby request that my recent medical records be released to:

The Pain & Rehab Institute
William C. VanNess, III, MD
116 Morlake Dr., suite 204
Mooresville, NC 28117
704-663-3777 Fax: 704-664-6615

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information unless otherwise noted. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at anytime. This consent will not expire without my expressed revocation.

By Law (HIPAA Omnibus), we <u>CANNOT</u> refuse to send your medical record to another physician involved in your care. (2010 Federal rules and regulations) Please make sure you complete the information below and if you see any physician that you do NOT list below, that you ask them to sign a release of information to send to our office if they need to request your medical records from this office.

Patient Signature: _____ Date: _____

Address: _____