146 Medical Park Road, Suite 108
Mooresville, NC 28117

Phone: 704-662-0877
Fax: 704-662-0875

LAKE NORMAN
ANESTHESIA ASSOCIATES
&
PAIN MANAGEMENT

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

**Patient Information:**

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

Phone _____ Social Security # _____

**I hereby request that my medical records be released FROM:**

Name _____

Address _____

Phone _____ Fax _____

**I hereby request that my medical records be released TO:**

Name Lake Norman Anesthesia Associates and Pain Management

Address 146 Medical Park Road, Suite 108, Mooresville, NC 28117

Phone (704) 662-0877 Fax (704) 662-0875

**This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.**

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that released information may include a communicable disease diagnosis such as HIV.

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)