Dr. John Cipriani, DC, President
Dr. Nevin Markel, DC
Dr. Ryan Shum, DC

Authorization to Release Medical Information

Date: ___________

____

Patient Name | Date of Birth | Phone Number

____

Street Address | City | State | Zip Code

Please Check the Appropriate Box:

☐ Please send records to my insurance provider--- Dates: ____

☐ Please send records to me --- Dates: ____

☐ Please send records to another physician --- Dates: ____

☐ Please send records to my attorney --- Dates: ____

I authorize Pain Relief & Wellness Center to release my medical records to:

____

Name | Company/Office

____

Street Address | City | State | Zip Code

____

Phone Number | Fax Number

____

Patient Signature | Date

I understand that my authorization is confidential, except for any action already taken in good faith and may be voided by the Pain Relief & Wellness Center or patient at any time for any reason. Unless otherwise indicated this release is valid for one (1) year from date of signature.

Please Note: The information contained in this document is privileged and confidential. It is for the use of the name recipient only. Pain Relief & Wellness Center, its officers and employees are release from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Lake Norman: P- 704.896.1811 F- 704.896.1812 **Charlotte: P- 980.819.8020 F- 980.819-8545**