10 PAGE DRIVE • PO BOX 1749 • PINEHURST, NC 28370
Phone Number: 910-295-6868 • Fax Number: 910-295-1514

Chart# _____

RELEASE OF MEDICAL INFORMATION FORM

Patient's Name: _____ Birth Date: _____
Home Address: _____
Town or City: _____State: _____ Zip: _____
Home phone: _____ Cell Phone: _____

I authorize _____ to release medical information from my medical records to:

☐ Pinehurst Neurology, P.O. Box 1749, Pinehurst N.C., 28370
Check One: ☐Dr. Jonathan Richman ☐ Dr. Misty Sinclair ☐ Dr. Robert Snyder
☐ Joyia Montanez, NP ☐ Grant Bischof, PA-C ☐ April Ridenhour, PA-C

☐ Name of Organization: _____
Organization Address: _____ Telephone: _____
Town or City: _____State: _____ Zip: _____
Fax : _____

This information should include:

☐ Initial Evaluation
☐ Lab Test
☐ Follow up visits
☐ Medications
☐ CT/Xray
☐ MRI/MRA

Other: _____

_____

This data shall include any relevant information concerning the above patient seen by you. This authorization for the release of medical records is fully understood and is made voluntarily on my part.

_____ _____
Patient Signature Date

_____
If not patient state relationship

_____ _____
Witnessed Date