Exhibit PRIV.017-A
GULF COAST BRAIN SPORT & SPINE, LLC
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN: _____
Address: _____Phone No: _____

I hereby authorize Gulf Coast Brain Sport & Spine, LLC to disclose my protected health information, covered under privacy and security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (referred to as "HIPAA Privacy Rules") as provided in this Authorization.

Information to be Disclosed: I hereby authorize disclosure of the following: { } Entire file { } Notes { } Imaging reports { } Lab Reports { } Electrodiagnostic testing { }Other (specify)

Recipient of Medical Records:

{ } Fax_____

{ } Phone_____

{ } Pick up_____

Purpose of the Use or Disclosure: _____

Expiration: This Authorization will expire six months from the date it is executed unless otherwise specified in writing.

Revocation of Authorization: I understand that I may revoke this Authorization by submitting a written revocation letter to Gulf Coast Brain Sport & Spine, LLC provided that, such revocation shall not be effective with respect to any use or disclosure made by Gulf Coast Brain Sport & Spine, LLC in reliance on this Authorization prior to the date of receipt of my revocation.

Authorization is not a Condition to Treatment: I understand that Gulf Coast Brain Sport & Spine, LLC cannot require me to sign this Authorization in order to receive treatment.

Potential Re-Disclosure: I understand that the information used or disclosed by Gulf Coast Brain Sport & Spine, LLC or the recipient pursuant to this Authorization may be subject to re-disclosure by recipient without limitation.

Verbal Communications: This Authorization does not authorize verbal communications.

I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person authorized to permit release of records on Patient's behalf.

_____
Print Name of Person Signing

_____ _____
Patient or Patient's Personal Representative Signature Date

_____
Basis for Personal Representative's Authority to Sign