PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____
Phone #: _____ Email: _____

I hereby authorize Nexus Spine Institute, LLC, its affiliates, medical staff, employees, and their representatives to release my protected health information in the manner listed below and to the following:

Send by: (CHOOSE ONE) ____ FAX ____ EMAIL

Send to:

Name: _____

Email: _____ Fax: _____

Please send:

___ ALL RECORDS

___ SPECIFIC ITEM (please specifiy):_____

**Depending on the request, it can take up to 2 weeks to receive records, though most requests are fulfilled sooner

Patient's Signature: _____

Patient's Name (Please Print): _____