Neurosurgical Spine Institute
Dr. Marat Grigorov DO
333 Tamiami Trail S suite 397
Venice, Florida 34285

HIPAA Release Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Release of Information

I authorize the release of information: Please circle imaging, diagnosis, billing information, all medical records.

This Information may be release to the following person:

Name: _____
Name: _____
Name: _____

The release of information will remain in effect for 1 year and expire on: _____ unless otherwise stated in a written letter.

_____ Signature

_____ Date