Neurosurgical Spine Institute

Authorization to Release Medical Records

Name of Patient: _____
Date of Birth :_____
Date(s) of Service: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

- o Continuing Medical Care
- o Insurance
- o Legal Purposes
- o School
- o Personal Use
- o Social Security/Disability
- o Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

o History & Physical
o Laboratory Reports
o Diagnostic Reports
o Consultation Report
o Other: _____

The above information may be released (specified name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc) Phone Number/Fax Number

_____
Address (Street, City, State and ZIP)

FROM:

_____
(Doctor, Hospital, Attorney, Company Self, etc) Phone Number/Fax Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____

Signature:

_____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient