PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This form authorizes Pain and Spine Institute to send records on your behalf

PAIN AND SPINE INSTITUTE

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Medical record requests from another physician are sent free of charge as a professional courtesy. There is a $25 fee if you would like a copy of your own records or a lawyer's office requests a copy of your records. Please complete and sign, and then mail, fax, or email this form back to the office.

Patient Name _____ Date of Birth _____

Address _____

Phone # _____ Email _____

I hereby authorize Pain and Spine Institute, its affiliates, medical staff, and employees to release my protected health information to the following:

Name _____

Address _____

Phone # _____ Fax # _____Email _____

Please send:

_____ All Records (Office notes, imaging results, medication history, laboratory results, etc)

_____ Specific Items _____

Depending on your request, it may take 2-3 weeks to receive records, though most requests are fulfilled sooner.

This authorization will expire in six months except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected under federal privacy laws or regulations.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian Relationship to Patient if Applicable