inspired spine

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Patient Authorization for Release of Information

Patient: Please Print	Name:	Phone
	Address:	Social Security Number
	City, State, ZIP:	Date of Birth
Health Care Facility/ Provider	**WHO HAS THE INFORMATION YOU WOULD LIKE RELEASED?**	
	Facility Name:	Fax
	Address:	Phone:
	City, State, ZIP	
Requesting Party	**WHO SHOULD RECEIVE THE INFORMATION?**	
	Facility Name	Attention:
	Address:	Fax:
	City, State, ZIP	Phone:
Information to Be Disclosed	___Clinic Notes ___History & Physical ___Consultation Reports ___Radiology Reports	___Hospital Reports ___Pathology Reports ___Operative Reports ___ER Report	___Lab Report ___EKG/EMG/NCV Reports ___PT Notes ___Other
Reason for Disclosure	___Continuing Care ___Physician Consultation	__Personal __Attorney (fee)	___Insurance Company (fee)
Revocation	I understand that my signature is valid for up to one year from the date signed below. I understand that I can request, in writing, cancellation of the authorization at any time. I do not authorize re-release of this information to anyone. A copy of this authorization is a valid as the original. I understand that once the Tristate Brain & Spine Institute has disclosed health care information I have authorized, the Tristate Brain & Spine Institute has no control over the information and may no longer be protected by privacy laws. The Tristate Brain & Spine Institute will not condition treatment for any patient that refused to sign an authorization for release of Protected Health information.		
Authorization	**I authorize the above provider to release the information designated to the requestor**		
	Patient/Guardian Signature:		Date:
	Relationship to the patient:		Reason Patient is not able to Sign