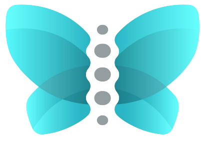

inspired spine

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Burnsville, MN 55337

Phone (952) 405-9760
Fax (855) 430-6952

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Patient Authorization for Release of Information

Spinal column records only

Patient *Please Print*	Name	Date of Birth
	Address	
	City/State/ZIP	Phone
Health Care Facility/Name	**RELEASE INFORMATION FROM:**	
	Facility/Name	Phone
	Address	Fax
	City/State/ZIP	
Requesting Party	**RELEASE INFORMATION TO:**	
	Facility/Name	Phone
	Address	Fax
	City/State/ZIP	
Information to Be Disclosed	Office Notes Physical Therapy Notes Operative Reports ER Reports Other (Specify below) ____________	Imaging Report Only Images on Disk + Report
Service Dates	From:____________ To:____________	
Reason for Disclosure	Continuing Care Insurance Personal Use Litigation/Legal	Other (Specify below) ____________

Authorization and Revocation

- ✓ This authorization is valid for one year after the date you sign it.
- ✓ This authorization may be canceled in writing at any time. A cancellation will not change releases that occured before the cancellation.
- ✓ Inspired Spine will not condition treatment for any patient that refuses to sign an Authorization to Release and Disclose PHI.
- ✓ A photocopy of this authorization will be treated in the same way as an original.
- ✓ Inspired Spine cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization. By signing this authorization, you release Inspired Spine from any and all liability resulting from a redisclosure by the recipient.
- ✓ Your signature indicates that you have read and understood the above statements and authorize the release/disclosure of your information.

Patient/Guardian Signature	Date
If other than patient, state relationship and authority to sign	