LUBBOCK SPINE INSTITUTE
COMPREHENSIVE SPINE TREATMENT

NEVAN G. BALDWIN, M.D.
SPINAL NEUROSURGERY

BOLKAR E. SAHINLER, M.D., FIPP
INTERVENTIONAL PAIN MANAGEMENT

BRIAN HIRSCH, M.D.
INTERVENTIONAL PAIN MANAGEMENT

JOSEPH L. MARTINEZ, M.D.
SPINAL NEUROSURGERY

ETHAN B. DALLEY, M.D.
INTERVENTIONAL PAIN MANAGEMENT

RYAN M. BAILEY, D.C.
CHIROPRACTOR

Authorization for use and Disclosure of Private Health Information

I hereby authorize the use of disclosure of my protected health information as described below.

PATIENT NAME:_____ **DATE:**_____

PATIENT SS#:_____ **DOB:**_____

Your information may be used for the following purposes: faxing reports, Release of films, Release of record(s), Release of OB pictures, Viewing records, Other Reasons:_____

Unless otherwise requested, physicians other than your referring physician can request and receive your health information. Name of other people allowed to request and receive my health information:

Myself _____**Spouse** _____**Other** _____**Family Member** _____**Care Taker**_____

Friend_____ **Other**_____

Request for visitor to attend this visit with me and to have access to communication concerning my protected health information:

Spouse_____ **Child** _____**Parent**_____ **Other** _____**Family Member**_____

Care Taker _____**Friend** _____**Other**_____

To carry out healthcare operations, this patient has authorized Lubbock Spine Institute to obtain previous medical records for comparison.

Patient Initials:_____

This authorization shall be in force and effect until the following date, at which time this authorization to use or disclose this PHI expires:

6 years _____**Other:**_____

I understand that the information in my health records may include information relating to sexually-transmitted disease, acquired immunodeficiency symptoms (AIDS), or human immune deficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. ___ Yes, I consent to the release of this information. ____ No, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to Mindy Jackson Lubbock Spine Institute at 3601 21st St., Lubbock, TX 79410. I understand that the revocation is not affected to the extent that Lubbock spine institute has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to consent a claim under the policy or to contest the policy itself. I understand that the revocation will not apply to the information already released in the response to this authorization.

I understand that Lubbock Spine Institute will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If the reason exists under law conditioning my treatment on obtaining this authorization I have been advised of the fact and of the consequence to me of refusing to sign this authorization. I understand that I may inspect or copy the information will not apply to information to be used or disclosed, as provided in CFR 164.524.

I understand that there is a potential for information used or disclosed pursuant to this authorization to be subjected to re-disclosure by the recipient and no longer protected by federal or state law.

I read and understand the Privacy Policy for Lubbock Spine Institute. I understand my rights and know this possibly is in a good standing until otherwise modified.

_____ _____

Signature of Patient of Personal Representative **Date**

_____ _____

Signature of Lubbock Spine Institute Representative **Date**

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MRI history

Date: _____
Name: _____
Date of birth:_____ Age:_____ Sex: M F Weight:_____lbs.
Please list any allergies to medications: _____
Have you had any prior surgery? If yes, list:_____
Are you on dialysis? YES NO
Have you ever had cancer?____ If yes, please explain_____
Women: are you or could you possibly be pregnant? YES NO
Have you had prior imaging studies of the area being scanned today? YES NO What facility?
X-rays_____ CT_____ MRI_____ Other_____
Have you ever worked in a machine shop or similar environment where you have been suggested to small metal slivers? YES NO

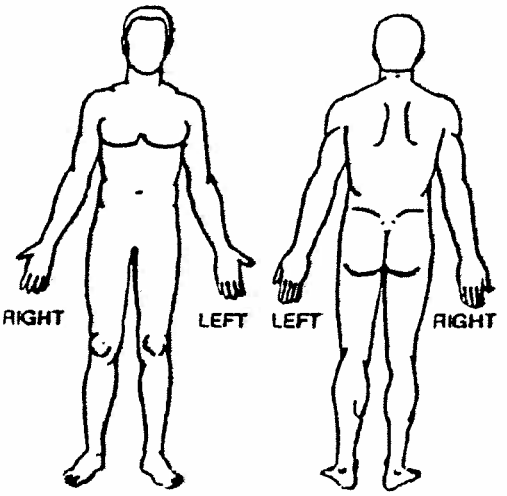
The following items may be hazardous or interferer with MRI imaging. Please indicate if you have the following:

__Cardiac Pacemaker / Defibrillator
__Intracranial Vascular Clips, Aneurysm Clips
__Dental work that is removable
__Mental fragments in or around eyes
__Ear implants (Cochlear)
__Neurostimulator, Insulin pump, Infusion pump
__Heart Valve Prosthesis, Ocular (eye) Implants
__Shunt: Spinal / Ventricular / Renal
__Liver Disease, Cirrhosis, Liver Failure
__Any other implant item:_____
__Joint Replacement: Bone or Joint / Plates / Harrington rods
__Renal Disease, Solitary Kidney
__Renal Transplant, Kidney Cancer
__High Blood Pressure >140/90
__Diabetes
__Shrapnel or Bullet
__Liver transplant last 6 months
__Hearing Aid
__Adhesive Medication Patch
__Claustrophobia
__Dialysis

*Date of Injury: _____
*When is your next appointment with the doctor that referred you for this test? _____
*Please list the symptoms / complains for which this test was requested:_____
_____

X _____
Patient / Guardian Signature

SPINE:
Pain located in: (CIRCLE ONE)
Lumbar Thoracic Cervical None
Pain radiates to: (CIRCLE ONE)
Arm Leg On the: (CIRLE ONE) Right Left
Prior surgery for this condition?
YES NO DISC LEVELS_____
FOR OFFICE USE ONLY:
Exam: _____ Lot #:_____
Contrast used_____ CC Omniscan, Multihance, Magnevist
Injected by:_____ Existing IV _____Stick_____
eGFR_____ Inj. Site_____



3601 21ST STREET · LUBBOCK, TEXAS 79410 · PHONE: 806-797-2222 · FAX: 806-792-7287

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RELEASE OF INFORMATION

I herby authorize Lubbock Spine Institute and/or Lubbock Diagnostic Radiology, L.L.P. in Lubbock, Texas, and/or any attending or consulting radiologist, who has treated, all rights, title and interest in any payment due for services described herein as provided in the policy or policies of insurance. I agree to pay at Lubbock, Texas, the charges of said facility and/or attending or consulting radiologist which exceed the amount paid by the insurance company or companies.

A photo static copy of the authorization shall be considered as effective and valid as the original.

Date:_____ Signature of Insured: X_____

Witness: _____

Signature of Lubbock Spine Institute Representative

THIS FORM ALLOWS LUBBOCK SPINE INSTITUTE
AND/OR LUBBOCK DIAGNOSTIC RADIOLOGY, L.L.P
TO FILE YOUR INSURANCE AND COLLECT FROM YOUR INSURANCE COMPANY

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