Release of Protected Health Information

Authorization for: ☐ Disclosure ☐ Inspection ☐ Amendment

Name of Patient: _____ Phone Number: _____

Address: _____City:_____State: _____

Other Names Used: _____ D.O.B:_____ Last Four of SSN: _____

By signing this form, I authorize you to release my confidential health information, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician(s)/ person/ facility/ entity listed below:

I hereby authorize: _____

May Release to: _____

_____

_____

PATIENT INFORMATION IS NEED FOR: PLEASE SELECT ONE OPTION

☐ Continuing of Care ☐ Military ☐ Personal Use ☐ School ☐ Insurance

☐ Legal Purpose ☐ Social Security Disability ☐ Other _____

DATE(S) OF TREATMENT: _____

INFORMATION TO BE RELEASED:

☐ History & Physical ☐ Consultation Report ☐ Operative Report

☐ Discharge/ Death Summary ☐ Lab/ Pathology ☐ Radiology Reports

☐ Radiology Images ☐ Entire Records ☐ Other: _____

METHOD OF DELIVERY:

☐ MAIL ☐ FAX ☐ PICK-UP

This authorization expires in one (1) year from the date signed below and cover only treatment (s)
For the date specified above.

_____

I, the undersigned, have read the above and authorize the staff of Lubbock Spine Institute to disclose such information as hereby contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may be no longer protected. I hereby release and hold harmless above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____

Date **Signature of Patient/Parent/Guardian** **Authority/Relationship Of Patient**