



# LUBBOCK SPINE INSTITUTE

COMPREHENSIVE SPINE TREATMENT

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### 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