We Improve Lives.

Request for the Release of Medical Information

Patient Information

Last Name, First Name ______________________ Date of Birth ______________________

Address ______________________ SSN XXX-XX-______________________

______________________ Phone 1 ______________________

City, State, Zip ______________________ Phone 2 ______________________

I authorize o The Virginia Spine Institute o ______________________ *to release medical records to*:

Name of Facility/Person ______________________ Relationship to Patient ______________________

Address ______________________ Phone ______________________

City, State, Zip ______________________ Fax ______________________

Method of Delivery: o Pick up at our office o Mail to address above o Fax to number above

Information to be Disclosed

- o Discuss Treatment
- o Radiological Imaging
- o All Records
- o Radiology Reports
- o History & Physical
- o Other / Date Range: ______________________
- o Operative Reports
- o Office Notes

Purpose of Disclosure

- o Continuing Care
- o Legal Investigation
- o Personal
- o Disability Determination
- o Change of Doctor
- o Other: ______________________

I hereby authorize disclosure of the health information for the above named patient. This information may include psychiatric, substance abuse, and HIV/AIDS information. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I may receive a copy of this authorization for my records. Unless otherwise specified, this authorization expires 2 years from date signed.

______________________ ______________________

Patient/Guardian Signature Date

______________________ ______________________

Printed Name Relationship to Patient

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