06.02.09

Print Form

Dallas Neurosurgical and Spine Associates , P.A.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ who resides at _____ City _____ State _____

hereby authorize: _____

(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address _____ City _____ State _____ Zip _____

To disclose the following specific medical information by ◯ mail ◯ fax ◯ email

to:

Name _____

Address _____ City _____ State _____ Zip _____

From the health records of:

Name _____

Address _____ City _____ State _____ Zip _____

For the purpose of: _____

Authorization extends only to those data elements/documents initiated below:

- ☐ Statements of charges or payments
- ☐ Records of visits (all visits)
- ☐ Record of visit for a specific date or dates — Specific dates include or are limited to: _____
- ☐ Copies of records or reports provided to the above named (i.e.hospital, lab, clinic, etc)
- ☐ Progress notes
- ☐ Photographs, videotapes, digital or other images
- ☐ Discharge Summary
- ☐ History and physical examination
- ☐ Consultation reports
- ☐ All of the above
- ☐ Other: Must be specifc: _____
- ☐ Mental Health and/or alcohol and drug abuse treatment
- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
- ☐ Hepatitis information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one-year period from the date signed, or sooner if noted below. The revocation must be in writing. (A revocation form is available from the receptionist.)

4. Dallas Neurosurgical and Spine Associates, P.A., its employees, officers, and physicians are hereby released from any legal responsibility, or liability for disclosure of the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining the Authorization..

6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

PATIENT'S NAME _____ DATE _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR _____

SSN _____ EXPIRATION DATE _____

(FOR IDENTIFICATION PURPOSES ONLY)

PATIENT'S PERSONAL REPRESENTATIVE _____ DATE _____

PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT _____

_____

WITNESS