SPINE
And Pain Physicians Surgery Center

AUTHORIZATION FOR RELEASE OF INFORMATION

Prohibition of Re-Disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.

PATIENT NAME: _____ DOB: _____

This will authorize **Spine and Pain Physicians Surgery Center** to

___ Release to ___ Receive from

NAME OF PERSON/ORGANIZATION: _____

ADDRESS: _____

PHONE: _____ FAX: _____

The information from my medical records, as listed below.

___ Imaging (Radiology) ___ OP NOTE ___ List of Medications ___ Complete Record

For the Purpose of:

___ Continuing Care ___ Collaborative Treatment ___ Other

This authorization will expire upon satisfaction of the need for disclosure, not to exceed 90 days after the date signed. I understand that I may revoke this authorization at any time and that upon fulfillment of the above stated purpose(s). I understand that in order to revoke this authorization, I must do so in writing. If I don't revoke this, I understand this authorization will automatically expire without my express revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

PLEASE FAX INFORMATION TO 615-459-3884 OR MAIL TO 1177 ROCK SPRINGS ROAD, SUITE 130, SMYRNA, TN. 37167