AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Last name:	First name:	SSN:	Date of birth:

AUTHORIZATION INFORMATION

I request and authorize Southeastern Spine and Joint release the information checked below to the following person(s) or entity:

☒ Medical Provider ☐ Parent/Guardian ☐ Myself ☐ Other_____

Entity, Medical Provider or Person's Name to which information should be released:	Address:	
Phone:	Fax:	Email:

INFORMATION TO BE RELEASED (select one)

- ○ All medical records to include all chart entries, diagnostics, test results and reports
- ○ All records related to visits on the following date(s)_____
- ○ All records related to the following diagnosis/symptoms_____
- ○ All medical records **EXCEPT**_____
- ○ Test results only from the following date(s)_____
- ○ Other _____

I authorize and request for my sole benefit the release of medical information which is part of my file at Southeastern Spine, Brain & Joint. This does not constitute blanket permissions for release of such information for an infinite period of time, but is limited to this instance only.

I agree that a copy of this release, electronic or faxed submission of this release shall be valid as this original release. I understand that if I authorized Southeastern Spine, Brain & Joint to fax or email the information, that there are inherent privacy risks with these methods.

_____ _____

Patient signature Date

FOR OFFICE USE ONLY

Copied: Initial _____ Date:_____ SENT: Mailed Picked-up Faxed Emailed

Initial:_____ Date:_____