



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

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

<p>All medical records to include all chart entries, diagnostics, test results and reports</p> <p>All records related to visits on the following date(s) _____</p> <p>All records related to the following diagnosis/symptoms _____</p> <p>All medical records EXCEPT _____</p> <p>Test results only from the following date(s) _____</p> <p>Other _____</p>

I authorize and request for my sole benefit the release of medical information which is part of my file at Southeastern Spine & 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 & 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: _____				