Southeastern Spine

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I Hereby Authorize: _____

_____

To Release To:

Southeastern Spine
Dr. James E Jolley, MD
Dr. James A. Ulibarri, MD
Jessica Scott, PA-C
Rebecca Payne, FNP-BC
Phone: 423-693-2175
Fax# 888-959-1015

(Downtown Office)
281 Lyerly Street, Suite 300
Chattanooga, TN 37404
or
(Ooltewah Office)
9309 Apison Pike
Ooltewah, Tn 37363

THE FOLLOWING RECORDS IN YOUR POSSESSION:

Progress Notes _____ X-Ray Results_____

Entire Record _____ Other (specify)_____

_____

FOR THE DATES OF TREATMENT:_____

This information is for the purpose of :
Referral To/From Another Physician _____
Patient Request_____

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I understand that this release is effective for one year from the date below and that it may be withdrawn from me in writing at any time.

Potential for Re-Disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulation.

PATIENT NAME:_____

DOB:_____ SS#:_____

_____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE