

MISSOURI SPINE INSTITUTE
Authorization for Medical Records Release

Patient Name _____ Middle Initial _____ Last Name _____

Address _____ D.O.B. _____

City _____ State _____ Zip _____

I, _____ authorize _____ to disclose the following

medical information to:

Company Name: Missouri Spine Institute, LLC

Address: 1616

Phone Number: _____ Fax Number: _____

This Authorization Extend Only to Document Initialed Below:

_____ Record of Visits From : _____ To: _____

_____ Progress Notes From: _____ To: _____

_____ Consultation Reports From: _____ To: _____

_____ Lab Results Type of Test: _____ To: _____

_____ Film Reports Date Taken: _____

_____ Discharge Summary Date of Discharge: _____

_____ History & Physical Examination Date: _____

_____ Statement of Charges/Payments From: _____ To: _____

_____ Hepatitis Information

_____ Mental Health or Illness

_____ Alcohol &/or Chemical Dependency or Treatment

_____ AIDS or HIV Information Testing or Status

_____ STD (sexually Transmitted Disease) Testing or Status

_____ Genetic Testing

_____ Other (Must Be Specific) _____

_____ **ALL OF THE ABOVE** (does not include Mental Health, Alcohol/Drug dependency or STD Testing/Status)

MISSOURI SPINE INSTITUTE
Authorization to Release Medical Records

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written permission.
2. I have the right to inspect or copy the Protected Health Information (PHI) to be used or disclosed.
3. I may revoke this authorization at any time, except where information has already been released, by completing the Missouri Spine Institute Revocation of an Authorization Form.
4. This authorization is valid for 60-Day period from the date it is signed, if below I do not provide an expiration date.
5. A photocopy fax of this Authorization Form is as valid as the original.
6. I understand that information uses or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
7. Missouri Spine Institute and its workforce members are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Please Print Patient's Name

Date

Patient/Personal Rep. Signature

Relationship to Patient

Witness

Date

Expiration Date (if other than date signed)

Revocation Date