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 Southridge Dr Ste 202 Jefferson City, MO 65109

Phone Number: (573) 635-0401 Fax Number: (573) 635-6715

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