Comprehensive NeuroSpine
Carlos Casas, MD – Neurosurgeon / Christine Whelan, RN – Business Practice Manager
Business Office: 1007 N. Federal Highway, #2010, Ft. Lauderdale, FL 33304-1422
Phone: 954-800-8877 – Fax: 954-800-5588 – Email: info@ComprehensiveNeuroSpine.com

CONSENT TO RELEASE AND/OR OBTAIN MEDICAL RECORDS

CNS MRN: _________________

Patient Name:___________________________________ D.O.B: _________________________

Instructions: Please read, then initial each item in the allotted space and sign the bottom of the form. Our office staff will witness your signature at time of your appointment.

______ I authorize **Comprehensive NeuroSpine** to request and obtain **ALL** medical information from my referring physician, my primary (family) physician, all treating physicians, Hospital and Diagnostic Centers where I may have been treated in the past, and to have these records faxed to 954-800-5588 or sent to **Comprehensive NeuroSpine** mailing address: 1007 N. Federal Highway, #2010, Fort. Lauderdale FL 33304-1422, ATTN: DR. CARLOS CASAS.

______ I authorize **Comprehensive NeuroSpine** to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release information to **Comprehensive NeuroSpine**.

______ I hereby authorize **Comprehensive NeuroSpine** to release copies of my medical records to:____
____ Fax #: ___________________________.

______ I understand that my request for **Comprehensive NeuroSpine** to send medical records to another provider may take up to 5 business days to complete. I agree to check the patient portals at all my provider's offices to help expedite this request for sharing my clinical records between my doctors.

______ I agree to keep these authorizations in effect until I provide written cancellation to **Comprehensive NeuroSpine**.

______ Comprehensive NeuroSpine, and staff is released from any legal responsibility of liability, for the release of my medical records to the extent indicated and authorized herein.

_____________________________ ________________________
Patient Signature Date

_____________________________ ________________________
Witness Date