MEDICAL RECORDS RELEASE
Authorization to Disclose Health Information

NOVASPINE PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts ™

PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____

Patient Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

INFORMATION TO BE RELEASED: (check all items to be released)

- ☐ Entire Record
- ☐ History and Physical
- ☐ Office Visit / Progress Notes
- ☐ Other:
- ☐ Period From:_____
- ☐ Urine Toxicology Results
- ☐ Operative Reports
- ☐ Medication List
- ☐ Lab Reports
- ☐ EMG/NCS Results
- ☐ Imaging Reports (X-rays, CT, MRI)
- ☐ Radiology Images CD / DVD
- ☐ All ☐ _____

REQUESTING RECORDS FROM:_____ _____

Special Records: I understand that protected information related to my diagnosis or treatment for AIDS/HIV, psychiatric care treatment, treatment for drug and alcohol abuse may be released as part of my health information. **Please check appropriate boxes below.**

AIDS/HIV Information	Psychiatric Care/Treatment	Treatment for Drug or Alcohol use/abuse
☐ YES, Disclose	☐ YES, Disclose	☐ YES, Disclose
☐ NO, do not disclose	☐ NO, do not disclose	☐ NO, do not disclose

PURPOSE/USE OF REQUESTED INFORMATION:

☐ Personal ☐ Treatment ☐ Insurance ☐ Disability ☐ Legal ☐ Other: _____

RELEASE INFORMATION TO:

Name: NovaSpine Pain Institute

Address: 13203 N 103rd Ave Ste H5 Phone: 623.777.4747

City: Sun City State: AZ Zip: 85351 Fax: 623.777.4748

FORMAT:

☑ Paper Copy ☐ Electronic Copy (provided on encrypted disk)

AUTHORIZATION:

- **FOR PERSONAL REQUESTS**: There will be a $0.25 per page fee for all requests on paper (plus the cost of postage and envelope) or there will be a $0.25 per page fee for all requests on CD (plus the cost of postage and envelope).
- **FOR DOCTOR TO DOCTOR REQUESTS**: There will be no fee. By default the past two (2) years of pertinent information will be sent. •
- I understand that I may revoke this authorization at any time, by notifying NovaSpine Pain Institute in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under the applicable law, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- My refusal to sign this authorization will not affect enrollment, eligibility for benefits, payment, or my ability to receive treatment.
- I understand that I may inspect or copy the information that is used or disclosed

Patient or Legal Representative Signature:_____ Date :_____

(If a personal representative executes this authorization, then the authorization must contain a description of the representatives authority to act for the individual, e.g., "parent" or "guardian ad litem")