AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Physician/Continuing Care (NO CHARGE): Records will be delivered directly to the provider specified by your facility. Personal Copy: Records will be delivered to the address indicated on your authorization. Please complete ALL fields to avoid any delay in delivery of your records.

I,_____, do hereby authorize Signe Spine & Rehab to receive/release my medical information as specified below.

PATIENT INFORMATION:

Print Full Name: _____ Birth Date: ___/___/___

Street Address: _____ SSN #: ___-___-___

City, State, Zip Code: _____ Phone: (___) ___-___

RELEASE TO:

Name of Company/Agency/Facility/Person: _____

Street Address: _____ Phone: (___) ___-___

City, State, Zip Code: _____ Fax: (___) ___-___

RELEASE FROM:

Name of Company/Agency/Facility/Person: _____

Street Address: _____ Phone: (___) ___-___

City, State, Zip Code: _____ Fax: (___) ___-___

DATES OF SERVICE: _____

REQUESTED RECORDS:

__Discharge Summary
__ History & Physical
__ Progress Notes
__ Operative Notes
__Laboratory Reports
__ Radiology Reports
__ Pathology Reports
__ Emergency Reports
__ Other (Specify):

PURPOSE OF DISCLOSURE:

__ Referral to Specialist
__ Disability Determination
__ Change of Doctor
__ Insurance
__ Personal
__ Legal Investigation
__ Workers Comp
__ Continuing Care
__ Other (Specify):

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that information in my health record may include information relating to Sexually Transmitted Diseases (STD's), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes the release of such information. I may refuse to sign this authorization form. I understand that Signe Spine & Rehab, LLC will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Signe Spine & Rehab LLC's Notice of Privacy explains the process for revocation, which included a request in writing. I understand that, if this information is disclosed to a third party, the information may no longer be protected by state and federal regulations and may be re-disclosed by the entity that receives the information. I release Signe Spine & Rehab, LLC, its physicians, employees, and business associates from any legal responsibility or liability for the re-disclosure of information by a third party. The patient / patient representative understand that a fee will be applied when records are released to any non-medical entity.

_____ _____

Signature of Individual or Guardian or Personal Representative of Patient's Estate

Date