

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Release to: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize Spine West, LLC to release the information specified below to the organization/individual named on this request.

#### INFORMATION REQUESTED

- |  |   |
|--|---|
| <input type="checkbox"/> Complete copy of medical record | <input type="checkbox"/> Consultation       |
| <input type="checkbox"/> Physical Therapy notes          | <input type="checkbox"/> Follow up Notes    |
| <input type="checkbox"/> Impairment Rating               | <input type="checkbox"/> Procedure Notes    |
| <input type="checkbox"/> Independent Medical Evaluation  | <input type="checkbox"/> EMG                |
| <input type="checkbox"/> Imaging Reports                 | <input type="checkbox"/> Laboratory Reports |

Other: \_\_\_\_\_

If the records are for yourself, please indicate how you would like to receive them: \_\_\_\_\_

#### I give specific authorization to disclose the following information

- |   |  |
|---|--|
| <input type="checkbox"/> HIV Test Results                       | <input type="checkbox"/> Documentation of AIDS Diagnosis             |
| <input type="checkbox"/> Drug & Alcohol Abuse Treatment Records | <input type="checkbox"/> Psychiatric/Mental Health Treatment Records |

#### PURPOSES FOR WHICH INFORMATION IS TO BE UTILIZED

- |   |  |
|---|--|
| <input type="checkbox"/> Further Evaluation/Treatment | <input type="checkbox"/> Insurance Reimbursement |
| <input type="checkbox"/> Legal                        | <input type="checkbox"/> Verify Treatment Status |
| <input type="checkbox"/> Personal Use                 | <input type="checkbox"/> Other                   |

#### EXPIRATION OR REVOCATION OF AUTHORIZATION

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous expressed revocation, this authorization will automatically expire 90 days from the date of my signature unless noted below:

- On \_\_\_\_\_ or  
 No longer than \_\_\_\_\_ days from the date of my signature or under the following conditions \_\_\_\_\_

**Signature:** A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized representative (please print) \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Authorized representative signature \_\_\_\_\_ Date \_\_\_\_\_

**Documented Identification** \_\_\_\_\_ (attach copy)

Completed \_\_\_\_\_