1031 WEST WILLIAMS STREET, SUITE 102, APEX, NC 27502
PHONE (919) 439-7867 FAX (919) 573-9594

Release Of Medical Information

Patient Name: _____
Date of Birth: _____ **SSN:** _____

I consent to and authorize: _____

Fax: _____ to disclose the health information for the above named patient.

Release medical records to:

Atlantic Spine & Pain
1031 West Williams Street, Suite 102
Apex, NC 27502
Phone: 919-439-7867
Fax: 919-573-9594

I hereby authorize Atlantic Spine & Pain to disclose health information for the above named patient to:

_____

Fax: _____

Description of information that may be used or disclosed:

The information may include medical information related to the treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and/or HIV/AIDS.

[ ] Complete medical record (including records relating to mental health care, communicable diseases, HIV/AIDS, and treatment of alcohol/drug abuse)
[ ] Clinic notes from the **last three (3) clinic visits** & **all imaging/procedure notes**.
[ ] Medical Information from the most recent visit/admission to include physician notes/summaries & diagnostic results
[ ] Other (please specify): _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law. I understand I may revoke this authorization at any time by sending a notice of revocation in writing to Atlantic Spine & Pain. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the Atlantic Spine & Pain Notice of Privacy.

This authorization expires _____ *(90 days if no date specified).*

_____ _____
Signature of patient or patient representative *Date*

_____
Relationship to patient