SPINE & PAIN PHYSICIANS

Consent for Release of Information

*****(This release also includes release of confidential related information) *****

Patient Name:_____

Address:_____ DOB:_____

City, State, Zip_____ Telephone:_____

Social Security # _____

I hereby authorize the above-named facility to release information from my medical record to: ☐ Healthcare Provider ☐ Patient

Name of Facility: _____

Address: _____

For the purpose of:_____

The specific information requested is: (please check one)

☐ Confined to records regarding admission and treatment for the following medical condition or injury:

_____ On or about (date)_____

☐ Covering records from (date)_____ to (date)_____

☐ Confined to the following specific information:_____

☐ Entire record

If the requested portion of the record contains information pertaining to drug or alcohol related diagnosis and treatment or contains HIV related information or information about mental health disorders or sexually transmitted diseases, you must specifically consent to the release of such information by signing one or more of the following:

I understand that if my records contain information concerning psychiatric, drug or alcohol related diagnosis and treatment, such information will be released pursuant to this consent form.

Signature of Patient or Representative: _____

I understand that if my records contain confidential HIV related information, such information will be release pursuant to this consent form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Signature of Patient or Representative: _____

I understand that if my records contain information concerning the diagnosis or treatment of sexually transmitted diseases, such information shall be released pursuant to this consent form.

Signature of Patient or Representative: _____

I understand that this consent can be revoked in writing at any time before the records are released. Unless I revoke this authorization in writing, it shall expire when the information is released in reliance upon this consent or under the following circumstances:

_____

(Date, event or condition of expiration)

_____ _____ _____

Signature of Patient or Representative Date If Representative, relationship to Patient

Patient must consent to release ENTIRE contents of a record containing HIV related information. If the patient named about is a minor, who does not have the legal right to consent to treatment, or has legally appointed guardian, this release must be signed by his/her parent/guardian.