The Spine Care Center & Spine Care Associates

Restoring Function. Relieving Pain.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____

Social Security Number:_____ Contact Phone Number:_____

Patient Address:_____

At the request of the individual, I (patients name) _____do hereby authorize (name of office/facility) _____ to release medical information concerning my medical treatment to the party listed below:

INFORMATION RELEASE TO:

Name:_____

Street Address:_____

City/State/Zip:_____

Phone Number:_____ Fax Number: _____

INFORMATION TO BE RELEASED/DISCLOSED:

☐ Complete Medical Record
☐ Specific Date Range from _____ to _____
☐ Other (please specify) _____

REASON FOR DISCLOSURE:

☐ Transfer of Care	☐ Attorney	☐ Insurance
☐ Workers' Comp	☐ Personal	☐ Other _____
☐ Second Opinion	☐ Disability	

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization and can be addressed to the company listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that there may be a charge for personal copies of my medical record allowed under Virginia Statute. The first fifty (50) pages $0.50 per page; every additional page over fifty is $0.25. (Please allow at least 48-72 hours to process your request)

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Sexually Transmitted Diseases (STDs), Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2)

Signature of Patient/Representative or Guardian:_____

Date (authorization will expire 12 months from date signed) _____