

The Spine Diagnostic & Pain Treatment Center

5408 Flanders Drive Baton Rouge, LA 70808

Phone: 225-769-5554

Fax: 225-769-5502

Authorization for Release of Medical Records Must Be Completed

I hereby authorize The Spine Diagnostic & Pain Treatment Center to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requested by: _____

Address: _____

Fax Number: _____

Patient Name: _____

Patient DOB: _____

Patient SSN: _____

Patient Address: _____

Contact Phone #: _____

Disclose the following PHI for treatment dates _____ to _____.

History & Physical Progress Notes Consult Billing

Physican Orders X-Ray Report Nurse Notes

Chart Notes MRI Results Other (specify) _____

The above information is disclosed for the following purpose(s):

Another physician Legal Insurance Personal Other

I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information.

This authorization shall expire upon this expiration date: _____

***If a specified date is not entered, the authorization will expire in six (6) months from the date the form was signed.

- I understand that I do have the right to revoke this authorization at any time and must do so in writing to The Spine Diagnostic & Pain Treatment Center. I understand that this revocation will not apply to information that has already been released pursuant to the authorization
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.
- My Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Legal Guardian _____ Date _____

Witness _____ Date _____