Advanced Spinal Care & Rehabilitation

1750 Southgate Parkway

Office: (740) 432-3634 Fax: (740) 432-7135

RELEASE OF HEALTHCARE INFORMATION AUTHORIZATION FORM

Patient's Full Name: ______________________________ Date of Birth: ________________

Previous Name(s) (if applicable): ____________________ Social Security: ________________

I request and authorize (facility/doctors name): ______________________________

To release healthcare information of the patient named above to: ______________________

Name: ____

Address: ____

City: ________________ State: ____________ Zip Code: _______

Phone: ______________________ Fax: __________________

This request and authorization applies to (circle all that apply): Impatient Outpatient Emergency

All Date(s) of service: _______________ Specific Date of Service: ______________________

- Treatment Notes
- Laboratory/Pathology Reports
- Surgical Reports
- Radiology/MRI Reports
- Intake Documentation
- Discharge Summary
- All records not requiring "Special Release"
- All records for this patient
- Other Please specify "other" records to be releases: ______________________

Psychotherapy Notes and STD Testing and/or results of test require a separate release. Should you wish to authorize release of this information, please request a "Special Release Authorization Form" from the Medical Records Department.

Patient Signature: ____________________________________ Date: __________________

THIS AUTHORIZATION EXPIRES SIXTY DAYS AFTER IT IS SIGNED.

PATIENT MAY WITHDRAW THIS AUTHORIZATION AT ANY TIME VIA WRITTEN REQUEST, SO LONG AS THE WITHDRAWAL REQUEST IS RECEIVED PRIOR TO THE RECORDS BEING RELEASED AS PER THIS REQUEST.