WAKE SPINE & PAIN SPECIALISTS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (please print) _____ Date of Birth_____/_____/_____

Persons/Organizations Providing the Information:

Name: Wake Spine & Pain Specialists, PC
Address: 3801 Wake Forest Rd, Ste 210
Raleigh, NC 27609
Ph. # 919-787-7246, Fax # 919-787-7247

Persons/Organizations Receiving the Information:

Name_____

Phone _____

Fax _____

Authorization for Release of Information covering the period of health care from _____ to _____

[ ] I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

I hereby **authorize the release of my complete health record with the exception of the following information:**
[ ] Mental health records
[ ] Communicable diseases (including HIV and AIDS)
[ ] Alcohol/drug abuse treatment
[ ] Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and in effect until _____, at which time this authorization expires. [Date or Event]

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I hereby authorize disclosure of my protected health information to Wake Spine & Pain Specialists. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.

_____ _____

Signature of Patient or Guardian **Date**