NORTHWEST
SPINE & PAIN MEDICINE

Patient Information:

Patient Name_____ Date of Birth: _____
Previous Name:_____ Phone Number:_____

Information to be released by: (Person/Organization providing the information)

Name of Office/Facility: Attn:_____
Address:_____
Phone Number:_____Fax Number: _____(_____

Information to be released to: (Person/Organization receiving the information)

Name of Office/Facility:_____ Attn:_____

Address:_____
Phone Number:_____Fax Number: _____

Information Requested: (Please select one)

- ☐ Most recent 2 years of relevant information (visit notes, lab results, radiology findings, pathology reports, operative, and procedure notes)
- ☐ Specific information (please specify, i.e. visit notes only) _____
- ☐ All medical records

Purpose for which the disclosure is being made: (Please select one)

☐ Legal ☐ Insurance ☐ Continuity of Care
☐ Personal Use ☐ Military

I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/or alcohol abuse, sexually transmitted diseases (STDs), acquired immune deficiency syndrome (AIDS), and/or HIV Status.**

I understand and agree that unless I specify otherwise, all medical information including the diagnoses and treatments described above may be released.

Please initial this statement if you do **not** authorize The release of the information described above. ☐ I do **not** authorize the release of the information listed above.

- I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that Inland Neurosurgery and Spine Associates will not deny treatment or payment based upon whether I sign this authorization.
- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- I understand that I am entitled to a copy of this authorization after I sign it.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)