Spring Spine Center

6535 FM 2920 Suite 200 • Spring, Texas 77379

(281) 376-1288 • FAX (281) 378-4706

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Steven S. Smith, D.C., P.A. to _____release to: _____ receive from:

DR OR HOSPITAL NAME | TELEPHONE

ADDRESS | FAX

CITY | STATE | ZIP CODE

Information/copies from the medical records on:

PATIENT | SOCIAL SECURITY

DATE OF BIRTH | DATES OF SERVICE

Information to be released:

___ History & Physical ___ Radiology Reports ___ Billing Records
___ Consultations ___ Radiology Films ___ Other

This information is being released for the following purpose:

___ Continued Care ___ Attorney/Litigation ___ Insurance ___ Disability Services
___ Other_____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in event this authorization shall expire (180) days from the date of my signature, unless specified in writing here: _____.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non health care provider; the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REP | DATE

PRINT NAME OF LEGALLY AUTHORIZED REPRESENTATIVE: | RELATIONSHIP TO PATIENT

WITNESS – PRINTED NAME/SIGNATURE | DATE