

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

NOTE: THIS AUTHORIZATION MUST BE COMPLETED, DATED AND SIGNED BY THE PATIENT OR A PERSON AUTHORIZED BY LAW TO GIVE AUTHORIZATION.

I hereby authorize _____ to release a copy of the medical information of

_____ SS#: _____ DOB: _____

(Patient's Name)

TO:

**The Spine Clinic, Inc.
1281 Lancaster Dr. NE
Salem, OR 97301
Phone: (503) 362-5555
Fax: (503) 362-7250**

The information will be used on my behalf for the following purpose:

To share clinical information with another healthcare facility/provider.

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ All clinical records, including chart notes and progress reports. _____ Billing statements.
_____ Diagnostic imaging studies and findings (X-Ray, MRI, CT, PET, SPECT, EKG, EEG, Ultrasound).
_____ Laboratory reports. _____ Pathology reports. _____ Physical therapy records.
_____ Medical records for continuity of care only. _____ Most recent five year medical history.

- This authorization is limited to the following treatment: _____.
- This authorization is limited to the following time period: _____ to _____.
- This authorization is limited to injuries related to an automobile accident occurring on: _____.
- This authorization is limited to injuries related to an on-the-job injury occurring on: _____.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing and shall remain in effect for the period reasonably needed to complete the request. I hereby authorize you to accept a photocopy of this authorization as the original.

(Date)

(Signature of Patient)

(Date)

(Signature of Person Authorized by Law)