The Southeastern Spine Institute
1106 Chuck Dawley, Mount Pleasant SC 29464
FAX#: (843) 284-5221

Authorization for Release of Medical Information

_____ _____ _____
Print Patient's Full Name | Birth Date (MM/DD/YYYY) | Home Telephone Number

_____ _____
Street Address City, State, Zip Code | Social Security Number

At the request of the individual, I _____, do hereby authorize The Southeastern Spine Institute to release:

_____ Discharge Summary
_____ History & Physical
_____ Progress Notes
_____ X-rays
_____ Laboratory Reports
_____ Radiology/MRI Reports and MRI/X-RAY CD
_____ Medication List
_____ Operative Notes
_____ Other

_____ **I DO** _____ **I DO NOT** Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

_____
Name (Physician, Hospital, Agency, etc.)
_____
Street Address
_____
City, State, Zip

PURPOSE OF DISCLOSURE:

_____ Referral to Specialist
_____Continuing Care
_____ Legal Investigation
_____ Insurance
_____Change of Doctor/Provider
_____ Disability Determination
_____ Workers Comp
_____ Personal/Self

Other (Specify) _____

I hereby authorize disclosure of the health information for the above names patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification or cancellation. I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. The form authorizes release of information in accordance with Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 5701 and 7332 that you specify.

_____ _____
Signature of individual or guardian or Personal Representative of Patient's Estate | Date

_____
Reason for transferring

Charges for records: .HIPAA rule 45 C.F.R. 164.52 (c) $2.00 cost-based fee for reviewing information access request, $0.20 per page cost-based fee for compiling and reproducing pages. For mailed request only: $0.01 per page mailing cost for paper and toner. $0.15 per envelope mailing cost. for patient only. Records will be processed in 7 to 10 working days.