Patient Authorization to Release Medical Information

LASER SPINE INSTITUTE®

This form allows Laser Spine Institute, LLC, to release records on your behalf.

Laser Spine Institute, LLC
Medical Records Department
5332 Avion Park Drive
Tampa, FL 33607
Phone: 1-866-362-7574, ext. 140
Fax: 813-597-2616

Select the facility location where we peformed your surgery

Choose facility

Patient name: _____
Date of birth: _____ Last four digits of SSN: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone #: _____

I hereby authorize Laser Spine Institute, LLC, its affiliates, medical staff, employees and their representatives to release my protected health information in the manner listed below, and to the following:

Choose only one method to send by: ◯ Mail ◯ Fax ◯ Secure email (records will expire after 60 days if left unopened)

Records requested:

◯ All records (notes, labs, reports, images)
◯ Disc of ALL images (only)
◯ Specific item only (please list): _____

If images are requested, a mailing address must be provided or records will not be sent.

Send to:

◯ Send to the address listed above ◯ Send to a different address listed below

Name: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone #: _____ Fax #: _____ Email: _____

There may be a charge for copies of records, in accordance with federal and state laws.

This authorization is effective one (1) year from the date signed below, except when revocation or modification is requested in writing by the patient, legal guardian, power of attorney or health care surrogate accompanied by the applicable documentation. I understand that I have the right to revoke or modify this authorization at any time. I understand that if I revoke or modify this authorization, I must do so in writing and present my written request to the Medical Records Team. Additionally, I acknowledge my responsibility to confirm receipt by LSI of such revocation or modification; such confirmation is required via certified mail. I understand that the revocation or modification will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected under federal privacy laws or regulations.

I understand LSI will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

Signature needed

_____ _____
Signature of patient/guardian/power of attorney/health care surrogate Date

_____ _____
Printed name Relationship to patient

Use one form for each person from whom you wish LSI to send your health information. You may copy this form as often as needed.