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AUTHORIZATION TO RELEASE MEDICAL IMAGES AND REPORTS

Patient's Name: _____ Date of Birth: _____

Address: _____ Day Phone: _____

_____ Email: _____

I request all images and reports of the patient named above to be released from the Laser Spine Institute locale:

(choose one)

Year of Last Visit:

Reason for Release of Information: Personal Use

Send all images and records to:

Me at same address as above **$20**

My new healthcare provider below **$20**

Name: _____

Address: _____

_____

Email: _____

Fax : _____

This request and authorization applies to all my medical records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether positive or negative) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management (Clary) receives my notice in writing submitted to the address above. I understand once Clary discloses my health information herein, it may no longer be protected by federal privacy laws.

I understand I will *pre-pay* a $20 fee to reproduce images and reports.

Patient Signature _____ Date_____

Patient Authorized Representative: _____ Date_____

Authority to Represent Patient: _____