Release of Patient Records

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

I _____ authorize a Florida Department of Health (DOH) representative to obtain a copy of my medical records, pertaining to the Laser Spine Institute, and provide them to me. I understand this is the only copy of the medical records and the Department of Health will not be maintaining a copy. And I understand they will be sent via USPS, Certified Mail, Return Receipt Requested. The records will be placed on a Compact Disk (CD) and the CD is not password protected.

I attest I am the person listed below and the rightful owner of the medical records.

Patient Name (Print):_____Signature: _____

D.O.B.:_____ SSN:_____ Date: _____

Name of Authorized Person Other than Patient (Print): _____

Signature of Authorized Person Other than Patient: _____

Please mail the compact disc containing my records to:

Company name if applicable: _____

Contact person if different from above: _____

Street: _____

City: _____ State: _____ Zip: _____