Rhett B. Murray, M.D.
Joel D. Pickett, M.D.
Cheng W. Tao, M.D.
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Derrick H. Cho, M.D.
Holly Ann Zywicke, M.D.
Hayley B. Campbell, M.D.
Brent M. Newell, M.D.

AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Telephone Number: _____ SS #: _____

( ) I authorize HH Spine & Neurosurgery Center to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

( ) I authorize HH Spine & Neurosurgery Center to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

Purpose for Request: (Check One) ( ) Healthcare ( ) Insurance Coverage ( ) Personal ( ) Other

Type of Records Requested: (Check One)

( ) Specific information (Select one or more as applicable)

( ) Operative Report	( ) History & Physical	( ) Discharge Summary
( ) Laboratory Test Results	( ) X-ray Reports	( ) Myelogram/CT
( ) Nuclear Medicine Studies	( ) Angiograms	( ) EMG/NCS
( ) MRI report	( ) Office Notes	( ) Other _____

( ) All medical records related to a specific illness or injury

_____
Specify illness/injury Date(s) of Treatment

I understand that:

- My right to healthcare is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a written request to the address provided above except where a disclosure has already been made in reliance of my prior authorization.
- If the person of facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed..
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of patient: _____ Date: _____