MEDICAL RECORDS RELEASE / REQUEST

I, ____ DOB ____________ SS# __________________

(Print patient's name)

Phone: __________________ Fax: __________________ Email: ______________________________

herein give permission to *Neuroscience & Spine Associates*

1660 Medical Blvd, Ste 200, Naples, FL 34110 P 239.449.7937 / F 877.793.1399

to release my records to:

Name: ____

Address: ____Phone: ________________ Fax: ______________

OR request my records from:

Name: ____

Address: ____Phone: ________________ Fax: ______________

- **A copy of the *( ) COMPLETE MEDICAL* RECORD OR choose of the following:**

( ) Progress Notes / Consultation Reports

( ) Lab Report(s)

( ) Computed Tomography (CT or CAT) Scans

( ) X-Ray / MRI Report(s) and/or MRI Disc

( ) EEG/EMG Reports

( ) Medication List / Medication Allergies

( ) Surgical Procedures / Biopsy Report(s)

( ) Other: ________________

- **For the purpose of:** Personal Use ______ Insurance ______ Continuing Care ______ Legal ______ or Other: ______

- **Please initial to allow the designated facility to disclose information protected under federal law relative to**:

________ drug and/or alcohol treatment
________ psychiatric care
________ diagnosis or information specific to HIV, AIDS
________ Sickle Cell Anemia.

- **For dates of service** *from* __________ *to* __________ OR ALL DATES________.

- **I wish to allow the following person(s) access to my medical records.**

Name: ____ Relationship: ________________

Name: ____ Relationship: ________________

This authorization will expire 2 (two) years following the last date of service. After this date, Neuroscience and Spine Associates can no longer use or disclose patient records without a new authorization form.

I have read this authorization and understand what information will be used or disclosed, by Neuroscience and Spine Associates PL. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth. The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Neuroscience and Spine Associates, P.L. must receive the revocation in writing
** The patient's name, address, and patient number, if applicable. * The effective date of this authorization, and the recipients of the protected health information according to this authorization, * The patient's desire to revoke this authorization, the date of the revocation, and the patient's signature*. All revocations must be sent to:

Neuroscience and Spine Associates, P.L. Attn: Medical Records 1660 Medical Blvd. Ste. 200 Naples, FL. 34110

Revocations are not effective until received by Medical Records. I fully understand and accept the terms of this authorization.

Patient or Authorized Personal Representative: ____ **Date:**____________

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