Sherban Spine Institute, P.A.

RECORD RELEASE AUTHORIZATION

Doctor/Hospital_____
_____
_____

Address_____
_____
_____

I,_____, hereby authorize and request the release of any/all of my medical records to Sherban Spine Institute. Please fax any records to our main office at 844-752-8300.

If you have any questions, please feel free to contact our office at 844-733-3774.

Thank you in advance.

Patient Signature:_____ Date:_____

Printed Name:_____

_____ _____
If the patient is a minor, signature of the parent/guardian Date

Sherban Spine Institute, P.A.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of Birth:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Sherban Spine Institute to release my medical and/or billing information to the following individual(s):

1:_____ Relation to Patient:_____

2:_____ Relation to Patient:_____

3:_____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient Signature:_____ Date:_____