REGENERATIVE
SPINE & JOINT CENTER

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Release of Medical Records Form

I,_____, hereby authorize Regenerative Spine & Joint Center to (check the following that apply):

Use/Receive the following protected health information
from_____
_____
_____

Disclose the following health information
to_____
_____
_____
(Specifically describe the information to be used or disclosed including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected information is being used or disclosed for the following purposes:
_____
_____
_____(List specific purposes above)

This authorization shall be in effect until_____
(SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE),
At which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Regenerative Spine & Joint Center. I understand that a revocation is not effective to the extent that Regenerative Spine & Joint Center has relied on the use or disclosure of protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of patient or Personal Representative Description of Person Representative Authority