



**Medical Records Release Authorization**

**Patient Name:** \_\_\_\_\_

**SSN:** XXX-XX-\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby authorize Spine and Pain Institute of Nona, dba Nona Spine and Pain Institute, to release the following information on my behalf (check all that apply):

**Records Requested**

Demographic / Insurance Information

**Entire Medical Record**

From: \_\_\_\_\_ To: \_\_\_\_\_

**Partial Medical Record**

From: \_\_\_\_\_ To: \_\_\_\_\_

Dictated Notes / Reports

Radiology Reports

Laboratory Results

**Other:** \_\_\_\_\_

---

**Fees for Copies**

- **Personal Use:** \$1.00 per page (up to 25 pages); \$0.25 per page over 25 pages
- **Personal Injury:** \$1.00 per page (up to 25 pages); \$0.25 per page over 25 pages
- **Workers' Compensation:** \$0.50 per page
- **Continuing Care (Physician-to-Physician):** No charge
- **Authorization Signatures**

**Delivery Method (Select One)**

**Our Office— No Charge**

Fax (records must not exceed 10 pages)



**Physician Office** — *Charges Apply*

Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_

Office Phone: \_\_\_\_\_

Office Fax: \_\_\_\_\_

**My Home** — *Charges Apply*

Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

**Will Pick Up**

Name of individual (if not patient): \_\_\_\_\_

*Valid photo identification required at pickup.*

**Other:** \_\_\_\_\_

---

**Authorization Statement**

I understand that the records released may include information from other health care providers and administrative records. The information will be released only to the individual(s) or entity specified on this form and only until the expiration date listed below.

I understand that I may revoke this authorization at any time by submitting a written notice. The written notice must include:

1. Patient's name, Social Security number, and date of birth
2. Reference to this specific authorization and the name of the authorized recipient(s)
3. A statement revoking the authorization, the effective date of revocation, and the patient's or legal guardian's signature



I understand that once disclosed, the information may be re-disclosed by the recipient and may no longer be protected by federal privacy laws or regulations.

This authorization will expire **six (6) months from the date signed** unless otherwise specified.

**Patient / Legal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_