EASTERN
Headache & Spine

Authorization for Release of Protected Health Information

I give permission for Eastern Headache and Spine to:

_____Release to _____Receive from

Name of person/Doctor/Hospital/Facility: _____

Address: _____

Phone: _____ Fax: _____

Release the following:
_____Entire Record
_____Specific Dates of treatment: From: _____To: _____
_____Other_____

Purpose of disclosure: _____

Patient Name and Address: _____
_____
_____

Patient SS#: _____ D.O.B._____

I authorize Eastern Headache and Spine to release the above designated information contained in my medical record. I understand that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS results, diagnosis and/or treatment.

I understand that this authorization may be revoked by me (in writing) at any time except to the extent that action has been taken thereon. I understand that the information released may be subject to re-disclosure by the recipient.

As a professional courtesy, no cost is assessed for information released directly to another health care provider; all other releases are subject to reasonable costs for copying and distribution.

Patient or Authorized Representative Signature: _____
Date of Signature: _____

*This authorization expires in 60 days from date of above signature

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