Authorization for Release of Protected Health Information

I hereby give permission to Eastern Headache and Spine to provide me with a copy of my medical record.

Patient Name: ___________________________________ DOB: ___________

Address: ____

City: ______________ State: _____ Zip: ____________

Phone: _____________________________ Email: ______________________________

Release the following:

______ Entire Record

______ Specific Dates of treatment: From: ___________To: ___________

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.

Please send this signed form and a check for $10 to the office address below.

Patient Signature: ____ Date: _____________

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