Bermuda Spine Center

www.NorthRockSpine.com

To request release of medical information please complete and sign this form and return via e-mail or fax to Bermuda Spine

Patient Information

Patient Last Name_____First Name_____MI_____

Street Address_____Parish_____ Zip_____

Date of Birth_____Phone Number_____

Bermuda Spine Center has my permission to release information contained in the medical record of the above named patient.

Information Requested (please be specific):_____

Restrictions and/or Exclusions (if any):_____

Purpose of release:_____

Bermuda Spine Center will provide the information requested above to the following party:

Name_____

Street Address_____Telephone_____

City_____Parish_____Zip_____

I hereby authorize Bermuda Spine Center (BSC) to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded above. I am aware that BSC cannot control how the recipient uses or shares the information, and those laws protecting its confidentiality at BSC may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 1 year from the signature date. I can however, cancel this authorization in writing at anytime.

_____ _____

Signature of Patient (18 years of age or older) Date

_____ _____

Signature of Parent or Guardian (if minor patient) Date

Please make a copy of this release for your records