



Medical Records Release Form

I do hereby consent and authorize Axis Spine Clinic, LLC to release copies of my medical records.

Patient Name _____

Address | Street Number _____

City, State and Zip Code _____ Phone _____

Date of Birth _____ Social Security Number | Last 4 digits only XXX - XX- _____

RECORDS REQUESTED FROM AXIS SPINE CLINIC, LLC

Name of Physician or Staff Member _____

Office Address | Street Number _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

RECORDS TO USE OR DISCLOSE TO

Name of Person or Facility _____

Practice Address | Street Number _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

Please select all the specific documents that apply to your request:

- Clinic Notes Radiology Reports Nurses Notes
- Progress Notes Lab Reports EKG, EEG, EMG
- History & Physical Pathology Reports Consult Notes
- Discharge Summary Operative Reports Other _____

Please place your initials beside the options below to authorize the release of sensitive information pertaining to:

Mental Health _____ Drugs or Alcohol _____ Not Applicable: None of these apply _____

Genetic Testing _____ HIV/AIDS/other infectious diseases _____

Please select the purpose of your request:

- Continued Patient Care Attorney/Legal Insurance Social Service/Disability
- Worker's Compensation Personal Other _____

Please select how you would like to receive your request:

- Mail to address above E-mail Verbal Pick up at Practice **URGENT:** Fax to number listed above

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Patient Name _____ Medical Record Number _____

I UNDERSTAND:

- I may revoke this Authorization at any time:
 - The revocation will not apply to information that has already been released in response to this Authorization.
 - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Axis Spine Clinic.

- I may refuse to sign this Authorization:
 - My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.
 - A fee may be charged for copying the protected health information. Please see the Practice Manger for information.

I have been informed and understand the information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this Authorization form.

Patient Signature Date

Printed Name of Patient

Signature of Authorized Representative Date

Printed Name of Authorized Representative

Please explain Respresentative's authority to act on behalf of the Patient

Office Use Only

Date Processed _____ Stamps/Additional Notes _____

Processed By _____