AUTHORIZATION TO RELEASE MEDICAL INFORMATION

1. I AUTHORIZE:

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2. TO RELEASE RECORDS TO:

THE BONATI SPINE INSTITUTE

- 7315 Hudson Avenue, Hudson, FL 34667

Phone number: 727-868-9563

3. INFORMATION TO BE RELEASED: (Check all applicable)
☐ Office Notes/Consults ☐ Operative Reports ☑ Labs/MRI/X-Ray Reports/EKG ☑ MRI/X-Ray Films/CD
☐ H & P/Discharge Summary ☐ Neurological Reports ☐ Physical Therapy Other:_______________

SPECIAL AUTHORIZATION: Check boxes and sign immediately below. By signing below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: ______________________________ Date: ______________________________

4. RECORDS FROM THE TIME PERIOD: / / through / /

5. PURPOSE OF DISCLOSURE:
☑ Continued Medical Care ☐ Personal ☐ Insurance ☐ Legal ☐ Other _______________

6. This authorization will expire on the day the request is processed. I understand that I may revoke this consent at any time except to the extent that action has already been taken. I may refuse to sign this authorization and that it is strictly voluntary.

7. If the requestor or the receiver is not a health plan or a health care provider, the released information may no longer be protected by federal pivacy regulation and may be re-disclosed. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

8. The requestor may be provided with a copy of this authorization.

Print Patient's Name: ______________________________ Patients Signature : ______________________________

Date of Birth:_______________ SSN:__________________ Tel.:_______________ Date:_____________