BROWARD SPINE INSTITUTE, LLC

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MEDICAL RECORDS

I hereby request and authorize Broward Spine Institute, LLC (BSI) to release my medical records.

This Authorization is only good for the date listed below only. I understand if I need additional copies I may be subject to a charge of $1.00 per page for the first 30 pages and $.50 for every page thereafter.

X-Ray CD $15.00 Charge.

_____ _____ _____
Patient's Name Date of Birth Patient Number

_____ _____
Organizations Name Phone/Fax

_____
Address City State Zip Code

I authorize the release of my confidential medical records for the purpose of (check all that apply)

_____Personal Use _____Further Medical Care _____Social Security
_____Legal Investigation Action _____Insurance _____Other

I understand that if the person and/or organization listed above are not health care providers or health care clearinghouses that must follow the federal privacy standards the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
I understand that if I agree to sign this authorization, I have a right to receive a signed copy of the form right to refuse to sign this authorization. I understand that I am under no obligation to sign this form, the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign or not sign this authorization. I understand that I may revoke this authorization in writing at any time.

_____ _____
Patient's Signature Date

_____ _____
Authorized Person (if applicable) Date

ID Card #_____

Drivers License # _____

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).