251-607-6117
Fax: 251-219-0746

Authorization for Release of Information

Name: ______________________________

Address: ______________________________

DOB: ______________________________

Phone: ______________________________

_________ I hereby authorize Petersen Neurospine, LLC. to release my records to:
Name: ______________________________
Phone: ______________________________
Fax: ______________________________
Address: ______________________________

_________ I hereby authorize the release of my records to Petersen Neurospine from:
Name: ______________________________
Phone: ______________________________
Fax: ______________________________
Address: ______________________________

Reason for Release: ______________________________

____

_________ Release my complete record

_________ Release records between _______________ to _______________

_________ Release specific records
- _________ Progress Notes
- _________ Diagnostic/ MRI/ CT/ X-rays
- _________ Operative Reports
- _________ Labs
- _________ Other- Please Specify ______________________________

____

____

By signing below I am authorizing the release of my medical records as listed above.

______________________________ ______________________________
Signature of Patient Date