PETERSEN NEUROSPINE
THE CENTER FOR SPINAL HEALTH

Authorization for Release of Information

Name: _____

Address: _____

DOB: _____

Phone: _____

☐ **I hereby authorize Petersen Neurospine, LLC. to release my records to:**

If you have requested medical records for your personal use, there will be a charge of $1.00 for the 1st 25 pages, $0.50 for each additional page. Any additional charges for Mailing records will apply at patient expense.

Name: _____

Phone: _____ Fax: _____

☐ **I hereby authorize the release of my records to Petersen Neurospine from:**

Name: _____

Phone: _____ Fax: _____

Reason for Release:

_____

☐ Release my complete Chart.

☐ Release records between _____ to _____

☐ Release specific records ☐ Progress notes ☐ Diagnostic

☐ Operative Reports ☐ Labs ☐ Other _____

By signing below, I am authorizing the release of my medical records as listed above. The below signature will be valid 1 year from the date of signature.

_____ _____

Signature of Patient/ Parent Date

Petersen Neurospine, LLC.

6707 Airport BLVD. Suite D-100 Mobile, Al 36608

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