MARYLAND BRAIN, SPINE + PAIN
Specialists in peace of mind and relief of pain

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Maryland Brain, Spine + Pain
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print patient's full name _____ Birth Date (MM/DD/YYYY) _____

Street Address _____ Social Security Number _____-_____-_____

City, State, Zip Code _____ Phone – best contact _____

Who has the information to be released? _____
Name (Physician, hospital, agency, etc)

_____
Street Address

_____

_____
City, State, Zip Code

Phone/Fax #_____

Where do you want the information sent? _____
Name (Physician, hospital, agency, etc)

_____
Street Address

_____

_____
City, State, Zip Code

Phone/Fax #_____

INFORMATION TO BE RELEASED:

- ☐ DISCHARGE SUMMARY
- ☐ HISTORY & PHYSICAL
- ☐ PROGRESS NOTES
- ☐ OPERATIVE NOTES
- ☐ PATHOLOGY REPORTS
- ☐ LABORATORY REPORTS
- ☐ RADIOLOGY REPORTS
- ☐ OTHER _____

Dates: _____ to _____

PURPOSE OF DISCLOSURE:

- ☐ REFERRAL TO SPECIALIST
- ☐ LEGAL INVESTIGATION
- ☐ INSURANCE
- ☐ DISABILITY DETERMINATION
- ☐ WORKERS COMP
- ☐ PERSONAL

OTHER (SPECIFY)_____

☐ I do ☐ I do NOT authorize release of information related to AIDS (Acquired Immodeficiency Syndrome) or HIV (Human Immunodeficiency Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of the signature unless a different date is entered here_____. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorization is furnished may not condition it to me, on whether or not I sign the authorization.

_____ _____

Signature **of Individual or Guardian or Personal Representative of patient's estate** **Date**

_____

Print Name **of Individual or Guardian or Personal Representative of patient'sestate**

If you are not the patient **please provide current telephone number in the event we need to contact you:**_____