Active Spine Center, LLC

Medical Records Release

Patient Name:____ Date:____________________

Date of Birth:____________________________________ SS#:____________________________

I hereby authorize_______________________________to furnish to Active Spine Center, LLC and its employees any and all of my records and related information pertaining to my care and treatment. The medical records should include, but not limited to, medical histories, reports, charts, notes, letters, x-rays, films, MRIs, CT scans and reports, correspondence, consultations, examinations, prescriptions, diagnoses, tests and treatment.

I understand that this information is being obtained to assist in my evaluation and treatment.

I have the right to revoke this authorization in writing at any time, except to the extent information has been release in reliance upon this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____ ________________________

Signature of Patient or Legally Authorized Representative Date

____ ________________________

Name of Legally Authorized Representative Relationship

____ ________________________

Witness Signature Date

This release is intended to comply with the Health Information Portability and Accountability Act (HIPPA)

Active Spine Center, LLC

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