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**Orthopaedic Spine Surgeons**
Steven C. Humphreys, M.D.
John Andreshak, M.D.
**Physician Assistant**
Susan Reed, PA-C

# AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

**Patient's Full Legal Name:**_____ **D.O.B.** _____

**Former Name (s):** _____

**I authorize Kenai Spine to:** ☐ **Release To** ☐ **Obtain From:**

**Name:**_____ **Phone:** _____

**Address:**_____ **Fax:** _____

**Information to be Released or Obtained:**

- ☐ **History & Physical**
- ☐ **Discharge Summary**
- ☐ **Surgical Reports**
- ☐ **Emergency Reports**
- ☐ **Consultation Reports**
- ☐ **Laboratory Reports**
- ☐ **EKG Reports**
- ☐ **X-Ray Reports**
- ☐ **X-Ray Films**
- ☐ **Other:**

**For the Purpose of:**

- ☐ **Further Medical Treatment**
- ☐ **Personal**
- ☐ **Other**

**Date(s) of service:** _____

***note*The first copy of medical record is free of charge to patients. After first copy, it is $.10 per page charge.**

I acknowledge that the information to be released or obtained may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing in the Kenai Spine business office. I understand that the revocation will not apply to the information that has already been released or obtained in response to this authorization, and that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In absence of a revocation, this specific authorization will expire on ( if left blank, it will expire 90 days from date of signature). MAXIMUM time for authorization is one year from date of signature.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

I understand authorizing the use of the disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment.

_____ _____

**Patient or Representative Signature** **Date**

_____ _____

**Witness** **Date**