THE AMERICAN CENTER FOR
SPINE & NEUROSURGERY
Excellence in Minimally Invasive Care

712 S. Milwaukee Avenue
Libertyville, IL 60048

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ DOB_____ Date_____

I hereby request that the Practice provide me with the following (please check all that apply):

- ☐ All medical records on file
- ☐ Medical records related to the time period from _____ to _____
- ☐ Billing records
- ☐ MRI CDs/films and corresponding reports on file.
- ☐ Physical therapy notes/records

_____ Please mail the requested information to:

_____

_____

_____

_____ Please have the records available for me to pick up at a mutually agreed upon time.

_____ Please fax the records to _____ at _____.

I understand that I may change my mind and revoke this Authorization by notifying the Practice in writing. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that the Practice has already taken action where it relied on my permission. Send revocations to: The American Center for Spine & Neurosurgery, Attn: Medical Records, 712 S. Milwaukee Ave, Libertyville, IL 60048. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient, the Practice cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.

I have read and understand this Authorization and had a chance to ask questions about the disclosure of health information. I Authorize the Practice to use/disclose my health information as noted above.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

For Office Use Only: Date Received _____ Date Completed _____ Faxed/Mailed _____

Patient Signature (if picking up) _____ Date_____