Patient Authorization for Release of Medical Information

This form allows LSI, LLC to send records on your behalf

Laser Spine Institute, LLC
Medical Records Department
3031 N. Rocky Point Drive, E., Tampa, FL 33607
Phone: 813-289-9613 Fax: 813-597-2616

Patient Name_____ Date of Birth_____ Last 4 digit SS#_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Email_____

I hereby authorize Laser Spine Institute, LLC, its affiliates, medical staff, employees, and their representatives to release my protected health information in the manner listed below, and **to** the following:

Send by: (choose ONE): ☐ **Mail** ☐ **Fax** ☐ **Secure Email**

Send to:

Name:_____

Address_____ City_____ State_____ Zip_____

Phone#_____ Fax#_____ Email_____

Please send:

☐ **All Records (Notes, Labs, Reports, CD)**

or

☐ **Specific Item Only** (please list):_____

Depending on your request, it can take 2-3 weeks to receive records, though most requests are fulfilled sooner

This authorization will not expire except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written request to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. I understand LSI will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

_____ _____

Signature of Patient/Guardian/Power of Attorney/Healthcare Surrogate Date

_____ _____

Printed Name Relationship to Patient if Applicable

LASER SPINE INSTITUTE®