



LONG ISLAND SPINE SPECIALISTS, P.C.
Committed to Excellence, Committed to You

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Patient Authorization - Release of Medical Records & Disability Forms

Patient Name: _____ Patient Telephone #: () _____ - _____

I hereby authorize Long Island Spine Specialists, P.C., to disclose my entire information file. A fee is required.

Myself /pick up. Mail to home –additional fee may be required Other: Please list below

TYPE OF REQUEST	TOTAL COPIES	FEE PER COPY
Medical Records		.75 ¢ per page
Disability Form		\$15.00
CD		\$10.00 flat fee
Mailing Fee		.49¢ depending on weight
		Total Fee

Name: _____

Paid By: Cash _____ Check _____ Credit Card _____

Office notes, x-rays, procedure reports, diagnostic reports.

Please Read the Following Carefully Before Signing Below.

RE: HIV, Mental Health, Alcohol & Drug Treatment.

I understand that if my records contain information relating to my sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV); such information will be released pursuant to this authorization. Confidential HIV-related information indicating that an HIV test was done; HIV is present; HIV related illness, or AIDS; or any information concerning drug or alcohol abuse and/or treatment, or behavioral, mental illness services, psychiatric treatment, or Hepatitis C; such information will be released pursuant to this authorization.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this information, I must do so in writing and present my written revocation to the medical facility. I understand 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. Unless otherwise revoked, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the Federal Confidentiality Rules may not protect the information.

If I have any questions about disclosure of my health information, I can contact LISS at (631) 462-2225, ext 238.

X _____ **DOB** ____ / ____ / ____ **SS #:** ____ / ____ / ____
PARENT SIGNATURE

X _____ **Today's Date:** ____ / ____ / ____
PARENT/GUARDIAN