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 ☐ Please fax to this number: ____________________

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	

☐ Disclose medical: Other – listed below:

____

Paid By: Cash _____   Check ____   Credit Card _____

_x_ 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 carriers 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 #:** ____/_____/______

PATIENT SIGNATURE

X ______________________________________ **Today's Date**: _____/______/__________

PARENT/GUARDIAN

October 11, 2017