General Medical Records Release and

Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: ____
Address: ____
____
Phone Number: ____
SSN: ______________________________ Date of Birth_______/_______/_______

I, ____, authorize **COMMONWEALTH SPINE & PAIN SPECIALISTS** to disclose/release the following information. (Check all that apply.)

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe): ___________________________________
  ____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): ____

Please send the records listed above to:

THE PATIENT LISTED ABOVE

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other: ______________________________
  ____

This information shall expire no later than ____/____/____ or upon the following event ________________ (whichever is sooner).

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information (PHI) and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this PHI.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Printed name of Patient Representative's authority to sign for Patient *(parent, guardian, POA for healthcare, or executor)*.

1501 Maple Avenue • Suite 301
Richmond, VA 23226
PH: (804) 288-7246 • Fax: (804) 288-7245
www.CommonwealthSpineandPain.com