LEGACY
SPINE & NEUROLOGICAL SPECIALISTS

LEGACY NEUROLOGY
LEGACY NEUROSURGERY
LEGACY PHYSICAL THERAPY
PAVILION MRI
Specializing in Minimally Invasive Spine Care

MEDICAL RECORDS REQUEST AUTHORIZATION

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE NUMBER _____

The following individual or organization is authorized to make the disclosure:

_____ LEGACY NEUROSURGERY _____ LEGACY SURGERY CENTER _____ PAVILION MRI

_____ LEGACY NEUROLOGY _____ OTHER (PLEASE SPECIFY) _____

This information may be disclosed to and used by the following individual or organization:

_____ PATIENT _____ OTHER (PLEASE SPECIFY) _____

TREATMENT DATES _____ PURPOSE OF REQUEST _____

The following information is to be disclosed: (*please check each item*)

YES	NO	
_____	_____	PHYSICIAN NOTES
_____	_____	LAB RESULTS
_____	_____	X-RAY I MRI REPORTS
_____	_____	COMPLETE RECORD
_____	_____	OTHER (PLEASE SPECIFY) _____

SENSITIVE INFORMATION: I understand that the information in my record may indude information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavioral or mental heath services or treatment for alcohol and drug abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

(b) I understand that I mat inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

(*If I do not specify an expiration date, event or condition, this authorization will expire in 1 year.*)

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE