SOUTHWEST
SPINE & PAIN CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

I hereby authorize:	To release to:
Southwest Spine and Pain Center 652 South Medical Center Drive suite 110 St. George, UT 84790 Phone: 435-656-2424 Fax: 435-656-2828	_____ _____ _____ _____

I hereby authorize:	To release to:
_____ _____ _____ _____ _____	Southwest Spine and Pain Center 652 South Medical Center Drive suite 110 St. George, UT 84790 Phone: 435-656-2424 Fax: 435-656-2828 Email: medicalrecords@swsp.com

I request and authorize the above named health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released may include information regarding the following condition(s) which may be protected by Federal Law, Drug/Alcohol Abuse, Mental Health Problems, Sickle Cell Anemia, HIV/AIDS Infection, Sexually Transmitted Diseases.

INFORMATION TO BE RELEASED:

Dates of Service: _____

- ○ All chart records
- ○ Consultation(s)
- ○ Operative Report(s)
- ○ Pathology Report(s)
- ○ Radiology Report(s)
- ○ Laboratory Reports(s)
- ○ Billing Information
- ○ Other (specify)_____

FOR THE PURPOSE OF:

- ○ Further Medical Treatment
- ○ Moving/Relocation
- ○ At the request of the individual
- ○ Insurance claims
- ○ Attorney/Court Case
- ○ Change Physicians
- ○ Other (specify): _____

Confidential notice: The documents accompanying this release contain confidential information belonging to the sender. This information is legally privileged and intended for the use of the individual named above, if you are not the intended recipient, please notify the sender and dispose of the information received. Use of this protected information by anyone other than the recipient is strictly prohibited. This request will expire 90 days from signature date.

_____ _____

Signature of Applicant **Date**

Prepared by: ☐ Patient ☐ Parent of Minor Child ☐ Legal Guardian