

Request for Release of Medical Records
Florida Joint and Spine Institute, P.A.
6325 US Hwy 27 North Suite 201 Sebring, FL 33870
Sebring (863) 385-2222 Fax (863) 382-8765

I _____ Hereby Authorize
(Patients Name)

(Hospital, Individual, Doctors Office or Agency)

(Address)

To release Medical, Psychiatric, Alcohol, Drug and HIV information contained in my records to Florida Joint and Spine Institute, P.A.
Ashok Sonni M.D./Stephen F. Beissinger M.D./J.C. Alvarez M.D./Maury Fisher, M.D./P. Reddy M.D.

I understand that this consent is revocable upon written notice to the Clinic or Physician, except to the extent that action by the Clinic or Physician has taken in reliance on this authorization, and that this authorization shall remain in force for a twelve-month period. (Expiration Date: _____). In order to not affect the purpose for which it is given. Alcohol and Drug abuse information, if present has been disclosed from records whose confidentiality is protected by federal law. Federal Regulation (42CFR, PART II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by Such Regulations.

Date of Authorization: _____

Patient's Name: _____

Address: _____

Phone # _____

Date of Birth: _____

Social Security # : _____

What records we are requesting _____

Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Authority to act for Patient: _____ Witness: _____