



**AUTHORIZATION TO RELEASE  
MEDICAL INFORMATION  
(PLEASE PRINT CLEARLY)**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_

Maiden/Other Name \_\_\_\_\_

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**I authorize Laser Spine Institute, its employees and agents to release information contained in my Medical Record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services).**

Name to whom information may be released: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

The Purpose and Need for Such Disclosure: \_\_\_\_\_

*For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.*

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department at Laser Spine Institute. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

\_\_\_\_\_  
Signature of Patient/Parent/Personal Representative

\_\_\_\_\_  
Date

If you are signing as a parent, guardian, or personal representative of the patient, describe this relationship and the source of your authority to sign this form below.

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Source of Authority

**FAX YOUR REQUEST TO (813) 287-1912**

**OR YOU MAY MAIL YOUR REQUEST TO:  
LASER SPINE INSTITUTE  
ATT: MEDICAL RECORDS DEPARTMENT  
3001 NO ROCKY POINT DRIVE, SUITE 100  
TAMPA, FL 33607**