Serenity Body and Spine

5900 North Main Street, Suite 3, Dayton, OH 45415 • 937-812-9614

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Authorization for Use/Disclosure of Information: I, the above-named patient (or legal guardian on behalf of patient) voluntarily request and authorize my health care provider, Serenity Body and Spine, to use my protected health information in the manner that I have identified below:

I authorize and request that my health care information be ❑released to ❑received from:

Name of facility _____

Address _____

Phone _____ Fax _____

Information to be disclosed or released: I authorize the release or disclosure of the health information by checking the applicable box(es) below:

❑ All of my health information that the Practice or above-named facility has in its possession, including information relating to any medical history, mental or physical condition, and any treatment received by me.

❑ Only the following records or types of health information:

_____

_____

Term: This Authorization will remain in effect until the Practice fulfills this request, or I revoke this Authorization.

Redisclosure: I understand that the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I change my mind, I can revoke this Authorization by providing the Practice with written notice of revocation.

Signature _____ Date _____

Printed Name _____ Relationship to Patient _____

For information being released to Serenity Body and Spine