STRENGE
SPINE CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use of or disclosure of my individually identifiable health information as described below understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that this authorization is voluntary, and I may refuse to sign it. If I choose not to sign this authorization, I understand that any or all of my medical records will not be transferable to anyone including myself.

Patient Full Name: _____ DOB: _____

Person/Organization to provide the information:

Strenge Spine Center
2603 Kentucky Ave #102
Paducah, KY 42003

Phone: (270) 228-3973
Fax: (270 359-5046

Person/Organization to receive the information:

_____

_____

Fax/Email: _____

Specific description of information to be released, including dates: _____

_____

_____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing but if I do it won't have any effect on any actions that took place before receipt of the revocation.

_____ _____
Signature of the patient or patients representative Date Signed

_____ _____
Printed name of patient's representation Date Signed