



MIDLAND SPINE INSTITUTE

COMPREHENSIVE SPINE TREATMENT

GRAYSON KOVAL, M.D.
INTERVENTIONAL PAIN MANAGEMENT

Release of Protected Health Information

Authorization for: Disclosure Inspection Amendment

Name of Patient: _____ Phone Number: _____

Address: _____ City: _____ State: _____

Other Names Used: _____ D.O.B: _____ Last Four of SSN: _____

By signing this form, I authorize you to release my confidential health information, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician(s)/ person/ facility/ entity listed below:

I hereby authorize: _____

May Release to: _____

PATIENT INFORMATION IS NEED FOR: PLEASE SELECT ONE OPTION

- Continuing of Care Military Personal Use School Insurance
- Legal Purpose Social Security Disability Other _____

DATE(S) OF TREATMENT: _____

INFORMATION TO BE RELEASED:

- History & Physical Consultation Report Operative Report
- Discharge/ Death Summary Lab/ Pathology Radiology Reports
- Radiology Images Entire Records Other: _____

METHOD OF DELIVERY:

- MAIL FAX PICK-UP

This authorization expires in one (1) year from the date signed below and cover only treatment (s) For the date specified above.

I, the undersigned, have read the above and authorize the staff of Midland Spine Institute to disclose such information as hereby contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may be no longer protected. I hereby release and hold harmless above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

Date

Signature of Patient/Parent/Guardian

Authority/Relationship Of Patient