

MINIMALLY INVASIVE SPINE SPECIALISTS, S.C.

**PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous Name: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release health care information of the patient named above to:

Name: \_\_\_\_\_

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

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

\_\_\_\_\_ Health care information relating to the following treatment, condition, or Dates of treatment:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ All health care information

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_

This information will be disclosed for the following purposes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's authorized representative

Date signed

\_\_\_\_\_  
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)