PATIENT AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

This form allows SonoSpine, LLC to obtain records on your behalf.

SonoSpine, LLC
1019 Vista Park Drive, STE A-1
Forest, VA 24551
Phone: 1-888-957-7463
Fax: 1-888-274-3766

Patient Name: _____ Date of Birth: _____

Address: _____ Last Four Digits of SS#: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

I authorize that my protected health information as listed below be released to SonoSpine, LLC, its affiliates, medical staff, employees, and their representatives from the following:

Name of hospital/imaging center: _____

Address: _____ Phone #: _____

Information to be released:

___ Entire Record ___ Medical Record ___ Other: _____

Purpose of Disclosure:

___ Further Medical Care ___ Changing Physicians ___ Personal Use

___ Other: _____

I agree and acknowledge that my records are confidential and may not be disclosed without my written consent, except when otherwise permitted by law. I agree and acknowledge that this authorization is voluntary, and I may refuse to sign it. This authorization will not expire except when revoked by patient, legal guardian, power of attorney, or healthcare surrogate. I agree and acknowledge that I have the right to revoke this authorizations at any time in writing that I must present to SonoSpine, LLC, Clinical Operations Director. I agree and acknowledge that my revocation will not apply to information that has already been released in response to this authorization. I agree and acknowledge that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. I agree and acknowledge to indemnify SonoSpine, LLC, including, but not limited to, SonoSpine, LLC affiliates, employees, and agents, from any and all damages that result from a release of information in accordance with this consent prior to any revocation. I agree and acknowledge that SonoSpine, LLC will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian's Signature *(if Patient is under 18 years of age)* Date