

## PATIENT AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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

SonoSpine, LLC  
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