615 Mid Florida Dr., Suite 1
Lakeland, FL 33813
(863) 583-4445
Fax: (863) 225-5289

Release of information authorization

Type of authorization: Release of Protected Health Information to a designated person / entry.

Patient Name: _____ **Date of Birth:** _____

Maiden name, if applicable: _____

Address: _____

I authorize (from): _____ to release medical information, about me, to **Novus Spine & Pain Center**.

Description of information to be disclosed: I authorized a physician/facility noted above to disclose the following protected information about me to the person identified above.

Information requested: _____for the dates of/from _____ to _____. I understand that information in my medical records concerning HIV treatment/status, depression, mental, social, health issues, and drug/alcohol use will be released unless initialed below:

_____ Mental health _____ HIV _____ Drug/Alcohol

Purpose of disclosure: (please circle choice below)

1. Further treatment 2. Personal Records 3. Transfer Care 4. Other: _____

Expirations of Termination of Authorization: This authorization will expire upon completion of this transaction. You have the right to terminate this authorization at any time. This request will be honored except to the extent of any action already taken on this authorization prior to revocation.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person, or by mailing a request to: **Novus Spine & Pain Center, 615 Mid-Florida Drive, Suite 1, Lakeland Florida 33813 Attn: Privacy Manager**

Re-disclosure: We have no control over the person(s) you have listed to receive your protected in health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirement to the Privacy Rule and will no longer be the responsibility of Novus Spine & Pain Center. **I understand that if I refuse to sign and agree with this release, but in doing so, I will not have access to my records.**

Patient Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____