Spine Specialty sm
CENTER

DR. DOUGLAS A. LINVILLE
6005 Park Avenue, Suite 400, Memphis, Tennessee 38119
901-767-9500 Fax: 901-767-0911

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Physician to provide records: _____

Patient Name: _____

Social Security #: _____ **DOB:** _____

Release To: _____

Address or Fax: _____

Information to be released:

□ **Complete health record** □ **Lab/Radiology**

□ **Progress Notes only** □ **Specify Dates** _____

□ **Hospital/Surgical** □ **Other (specify)** _____

I understand that the information in my health record may include information related to sexually transmitted diseases, AIDS, HIV, behavioral or mental health conditions, and substance abuse. It may also include records from other sources that have been used in my care.

If you do not want certain portions of your medical records released, please specify

_____

I understand that I may revoke this authorization at any time and that unless an earlier date is specified; it will automatically expire 12 months after the date signed.

Signature of Patient _____ **Date** _____

Person authorized to sign for patient _____

Relationship to Patient _____