

**MEDICAL RECORDS RELEASE**

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

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize **(Facility Information)**

\_\_\_\_\_  
*Provider, Facility*

\_\_\_\_\_  
*Address, City, State, Zip Code*

\_\_\_\_\_ *Phone* \_\_\_\_\_ *Fax*

**The release the following information on my behalf:**

- Medical Record: from: \_\_\_\_\_ to: \_\_\_\_\_
- Notes     Radiology reports     CT CD/USB (DOS) \_\_\_\_\_     MRI CD/USB (DOS) \_\_\_\_\_
- Other \_\_\_\_\_

Please send records to:

**Deuk Spine Institute**  
**Attn: MRI Review**  
**7955 Spyglass Hill Rd Ste A**  
**Melbourne, FL 32940**

I understand these records may contain information from other health care providers, as well as information which is administrative in nature. This information will be given only to those specified on this form and only through the expiration date stated below. I also understand I have the right to revoke this authorization at any time through written notice and that written notice must include 1) the patient's name, social security number and date of birth, 2) make reference to this specific authorization and the name so those authorized by this form to receive information, 3) a statement that the patient wants to revoke this authorization, the effective date of revocation, and the signature of the patient or a legal guardian. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.

**This authorization will expire 1 year from the date specified below.**

\_\_\_\_\_  
*Patient/Legal Representative Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*Date*