

Authorization to Release Medical Information

I request and authorize the Front Range Center for Brain & Spine Surgery, P.C., doctor or doctors to release medical information obtained in the course of my examination and treatment to myself and all of the following. *Please note: We will be unable to release medical information to persons not listed below. Please indicate if access is authorized by checking the "yes" box beside the item.*

- yes My insurance company
- yes My Worker's Compensation carrier
- yes Any other insurance company such as a disability insurance company
- yes My current employer or any former employer
- yes My primary and/or referring physician
- yes Any health care people providing services involved in my medical treatment and management
- yes My attorney
- yes My emergency contact person
- yes My parents
- yes My spouse
- yes My adult children
- yes Other: _____

This authorization has been made voluntarily. Any information regarding my treatment or other condition that is not to be disclosed is specifically listed below and I will advise the treating neurosurgeon of such request not to disclose certain information.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

Date

Patient's name

X _____
Signature of patient, guardian, or power of attorney

Please print name if other than patient Relationship

Consent To Release Medical Records Not Generated In This Office:

I realize that records obtained from other providers and incorporated as part of the record of the Front Range Center for Brain & Spine Surgery, P.C. could contain information that I may consider sensitive. I understand that the Front Range Center for Brain & Spine Surgery, P.C. may not have had reason to thoroughly read the records they obtained from other providers, may not know if the records contain information I consider to be sensitive, or may not know if other providers have given them a complete copy of my previous records. By my signature below, however, I authorize the Front Range Center for Brain & Spine Surgery, P.C. to release this information.

X _____
Signature

Continued on other side

Authorization to Leave Information

I authorize Front Range Center for Brain & Spine Surgery, P.C., to leave messages containing medical information as follows. *Please check all authorized source(s) below:*

- home voice mail/answering machine
- business voice mail/answering machine
- cell phone voice mail
- email at:
- with an individual I designate as follows: _____

I understand that these messages may include, but would not necessarily be limited to, the following: radiologic test results, lab results, pre- and post-operative care instructions, and suggested courses of treatment.

I further authorize Front Range Center for Brain & Spine Surgery, P.C., to leave messages regarding issues of healthcare business, such as insurance authorizations and account management, on my voice mail, answering machine, or by email.

This authorization has been made voluntarily, and I understand that I may change the choices/information above by notifying Front Range Center for Brain & Spine Surgery, P.C., in writing.

Date

Patient's name (printed)

X _____
Signature of patient

Person authorized to sign for the patient

Relationship