AUTHORIZATION TO USE, DISCLOSE, or RELEASE
HEALTH CARE INFORMATION

Patient name: _____

Date of birth: _____

I hereby authorize_____ (print name of provider) to release information from my medical record as indicated below to:

Name: Coeur d'Alene Spine and Brain, PLLC

Address: 3320 N Grand Mill Ln City: Coeur d'Alene State: ID ZIP: 83814

Phone: 208-765-9100 Fax: 208-765-9103

INFORMATION TO BE RELEASED:

	Dates
Office visit/ progress notes	_____
Lab reports	_____
EKG Reports	_____
OP Reports	_____

Other: _____

I specifically DO NOT authorize the release of information for the categories below:
_____

PURPOSE OF DISCLOSURE:
Medical Treatment___ Legal ___ Insurance ___ Personal___ Disability determination___
Other (please specify):_____

I understand that this authorization will expire 90 days after I have signed the form. I understand that I may revoke this authorization at anytime by notifying the providing organization in writing. If I did, it would not affect any actions already taken by provider based upon this authorization. Once health care information is disclosed, the person or organization that receives it may re-disclose it, and privacy laws may no longer protect it. By authorizing the release of this information, I understand that my health care and payment for my health care will not be affected.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Print name if signed on behalf of patient Relationship
(Parent, legal guardian,
personal representative)