BSC BRAIN & SPINE CENTER
MEMORY CLINIC
Diagnose Modify Treat

Brain and Spine Center, PLC
4045 W. Chandler Blvd., Bldg. F
Chandler, AZ 85226

1760 E. Florence Blvd, Ste. 150
Casa Grande, AZ 85122

Office (480) 917-3706 **Fax** (480) 353-2066

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____ Date of Birth: _____

Maiden Name: _____

I request and authorize Brain and Spine Center, PLC to ☐ obtain ☐ release

Healthcare information of the patient named above to/from:

Provider Name/Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Description of Protected Health Information to be disclosed:

☐ Most Recent Visit Notes ☐ X-Ray Reports ☐ Lab Tests

☐ Other _____

Purpose(s) of the disclosure:

☐ Supplemental Care ☐ Transfer of Care ☐ Personal Use

☐ Second Opinion ☐ Workers' Compensation ☐ Legal

☐ Insurance Coverage or Payment of Care ☐ Other: _____

I hereby authorize Provider to release Protected Health Information ("Information") to Brain and Spine Center, PLC. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire NINETY (90) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

Patient Signature/Legal Representative: _____ Date _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER SIGNATURE DATE