(Provider of Release of Information Services for – Spine & Neuro)
**Release of Information Hours: Monday through Friday, 7:00am to 3:30pm**
**Closed on Holidays**

## ACKNOWLEDGEMENT OF MEDICAL RECORDS REPRODUCTION FEES FOR PATIENTS

To ensure that your medical records are kept confidential and private, it is necessary for you to authorize release of your records and provide a copy of a picture ID (Driver's license, Military or State/Government ID, Passport, Work Photo Badge, Non-Driver Identification card, or other photo identification).

Walk-in requests will generally be processed within 5-7 business days.

If your records are needed for treatment or for an appointment within the next 48-72 hours, your physician can request records by fax when you arrive at their office for treatment.

If medical records are needed for continuing care, there is no charge when records are faxed directly to your physician.

All other patient requests will typically result in fees for the patient.

**Fees for Patient Request:**

- **$0.12 per page**
- **USPS charges, as applicable**
- **No charges to veterans or active duty military personnel with military identification**
- **Methods of payment accepted: Debit Card, Credit Card, Personal Check, or Money Order (CASH IS NOT ACCPETED)**

By signing below, I acknowledge that I was informed of the fees required to obtain copies of my medical records.

Patient Name (Print): ______________________________________________

Patient Signature: ________________________________________________

Rhett B. Murray, M.D.
Joel D. Pickett, M.D.
Cheng W. Tao, M.D.
Jason T. Banks, M.D.
Holly Ann Zywicke, M.D.
Stephen E. Sandwell, M.D.
Hayley B. Campbell, M.D.
Brent M. Newell, M.D.
Christopher D. Hargett, D.O.

## AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL INFORMATION

Patient's Name:_______________________________________ DOB:_____________________________

Address:_____________________________________________ City:______________________________

State:____________ Zip:______________ Patient's Phone Number:______________________________

**I AUTHORIZE THE SPINE & NEURO CENTER TO RELEASE INFORMATION TO:**

**CHOOSE ONLY ONE:**

☐ **Provider/Facility:**

Provider/Facility's name:____________________

________________________________________

Phone Number:___________________________

Fax **OR** Email:_____________________________

☐ **Self (choose one method)**

☐ Email:___________________________________

☐ Mail:____________________________________

________________________________________

**Purpose for Request:** ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

**Type of Records Requested: (Check one or more, as applicable)**

☐ Operative Reports
☐ Laboratory Test Results
☐ Nuclear Medicine Studies
☐ MRI Reports
☐ Records from a specific date/injury (Specify) ______________
☐ All Records (May take 24-48 hours to retrieve entire chart)
☐ Other (Specify) _____________________________________

☐ History & Physical
☐ Angiograms
☐ Office Notes
☐ Discharge Summary
☐ Myelogram/CT Reports
☐ EMG/NCS
☐ X-Ray Disc

**I understand that:**
*My right to healthcare is not conditioned on this authorization.
*I may cancel this authorization at any time by submitting written request to the address provided above, except where a disclosure has already been made in reliance on my prior authorization.
*If the person or facility receiving this information is not a healthcare or medial insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
*Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
*There may be a charge for the requested records.
*This authorization is utilizable for up to one (1) year.

**Signature of Patient:** _____________________________________________ **Date:** ________________________

**Spine & Neuro Center Medical Records Department**
201 Governors Drive 1ST Floor • Huntsville, AL 35801 • 256-533-1600 Option 5 • FAX : 256-539-0856