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 REQUEST OF PROTECTED MEDICAL INFORMATION

Patient's Name:_______________________________________ DOB:______________________________

Address:____ City:______________________________

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

☐ **I AUTHORIZE THE SPINE & NEURO CENTER TO OBTAIN INFORMATION FROM:**

Name of Provider/Facility: ____

Address:_____________________________ City: ______________State_______Zip:_________________

Phone Number: __________________________ Fax/Email: __________________________________

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