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Thomas A. Ostergard, M.D.
Hayley B. Campbell, M.D.
Brent M. Newell, M.D.
Duncan L. Bralts, D.O.

SPINE & NEURO
HUNTSVILLE HOSPITAL

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 below, 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 medical 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