NEW ENGLAND SPINE CARE
Spine, Sports, and Regenerative Medicine
P: 617-547-7163 F: 617-547-7165 NeSpineCare.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name_____ Date of Birth_____
Daytime Phone #_____ Cell or Other_____
Address _____City _____ Sate_____ Zip _____

I , _____ hereby authorize New England Spine Care Associates and New England Ambulatory SurgiCenter to use, disclose or obtain the following protected health information with the indicated person(s) or institutions:

Date Range: _____ to _____ OR _____ All

Information: __Office notes (Consult/Follow-up) __Imaging/Tests __Procedure Notes __Full Chart

From NEASC/NESCA to another person or facility:

__ All physicians, insurances, worker's compensation or healthcare providers involved in my care
__Referring physician and primary care physician only
__Institution _____
__Other: _____ Address: _____

To NEASC/NESCA from another person or facility:

__ All physicians, insurances, worker's compensation or healthcare providers involved in my care.
__Institution _____
__Imaging Studies Other: _____

Release Information To:

New England Spine Care Associates
New England Ambulatory SurgiCenter
799 Concord Ave. Cambridge MA 02138 Phone: (617)547-7163 Fax: (617)547-7165

Purpose of Disclosure:

__Communication __Changing Physicians __Second Opinion
__Continuing Care __ Insurance __Other
__Legal /Workman's Comp __School

1. I understand that I may revoke this authorization at any time by notifying our Privacy Officer, in writing. Submitting a written request will terminate this authorization, unless it has already been acted upon.
2. I understand that my private health information will no longer be protected by federal privacy regulations. However, federal law prohibits disclosing specially protected information, such as substance abuse treatment, HIV/AIDs-related, and psychiatric/mental health information.
3. I understand that I could ask for a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization

_____ _____
Signature of Patient **Date**