Connecticut Neck & Back Specialists, LLC

Authorization and Consent to Disclose Medical Information

Patient Name: ____

Other Name: ____

Date of Birth: ____

The undersigned hereby authorizes **Connecticut Neck & Back Specialists, LLC**

to disclose information from the medical record of the above-named patient to the following

persons/organizations listed below:

______________________	______________________	______________
(Name of Person or Organization)	(Address)	(Relationship)
______________________	______________________	______________
(Name of Person or Organization)	(Address)	(Relationship)
______________________	______________________	______________
(Name of Person or Organization)	(Address)	(Relationship)

This information is to be released for the following purpose:

☐ Continuing Care ☐ Litigation ☐ Insurance Claim

☐ Other - Explain: ____

This consent to release medical information is limited to the following:

☐All Related Records ☐ Radiology Films ☐ Radiology Reports ☐ Office Notes ☐ Operative Reports

☐ Other - Explain: ____

I understand that I may revoke this consent at any time.

I do not authorize further release to any third party. I understand that once information is released pursuant to this authorization, the clinic, their employees and my physician cannot prevent the redisclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

______________________________ ______________________________

Signature of Patient/Guardian Relationship to Patient if Signed by Guardian

______________________________ ______________________________

Date of Patient's Signature Reason Patient Unable to Sign

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Witness:

A photostatic copy of this authorization shall be considered as effective and valid as the original.