Connecticut Neck & Back Specialists, LLC

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David L. Kramer, M.D.
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MEDICAL RECORDS AUTHORIZATION & CONSENT TO DISCLOSE INFORMATION

Patient Name: ____

Date of Birth: ____

The undersigned hereby authorizes **Connecticut Neck & Back Specialists, LLC** to release information from the medical record of the above-named patient to the following person/organization listed below:

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

EXPIRATION DATE:		**EXPIRATION EVENT:**
From (date):____/____/____ To (date): ____/____/____	**OR**	______________________ ______________________

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

☐ All Related Records ☐ Radiology Reports ☐ Office Notes ☐ Operative Reports ☐ Other:____________________

These medical records are to be released for the following purpose:

☐ Continuing Care ☐ Litigation ☐ Insurance Claim ☐ Other: ______________________

I understand that I may cancel this authorization at any time, in writing. If the practice has already used this authorization or if this authorization was used so that I could obtain insurance coverage, I may be unable to cancel the authorization. I understand that the practice will not condition treatment or payment based upon my signing this authorization. I am signing this authorization freely. No one has forced me to sign this authorization. I understand that the information disclosed could be redisclosed by the recipient, and then it is no longer protected by federal regulations. I understand that if the information disclosed is related to HIV/AIDS and/or alcohol/substance abuse that the recipient may not redisclose it under Connecticut State Law. I acknowledge that I have carefully reviewed this Authorization and understand its provisions. I hereby release **Connecticut Neck & Back Specialists, LLC** from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

☐ I permit the release of any of my records related to HIV, Alcohol & Drug Abuse, and psychiatric care.

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

______________________ ______________________
Date Reason Patient Unable to Sign

____
Witness:

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

______***FOR OFFICE USE ONLY***______________________

☐ Reviewed release of minor records with Administrator and/or Privacy officer Initials ____________
Date______________