MIDWEST NEUROSURGERY & SPINE
Adult & Pediatric SPECIALISTS

MEDICAL RECORDS REQUEST

Patient: _____DOB: _____SS#: _____

Address: _____

Hereby authorizes Midwest Neurosurgery & Spine Specialists to (check one or both):

- ☐ Release protected health information to:
- ☐ Receive protected health information from:

Name/Office: _____

Address: _____

City/State/ZIP: _____

Fax: _____Phone:_____

Specific information to be disclosed (check all that apply):

- ☐ Medical Records (i.e. office notes, progress reports)
- ☐ Billing Statement
- ☐ Radiology Reports
- ☐ Images (i.e. MRI, X-Ray, CT)
- ☐ Complete Record
- ☐ Verbal Communication Only
- ☐ Other: _____

Date(s) of service to be disclosed: _____
Specify time frame or "All"

PATIENT RIGHTS REGARDING THIS AUTHORIZATION:
I have the right to inspect or request a copy of this authorization. I understand there is no obligation to sign this authorization and that I may refuse to sign it. I have the right to revoke this authorization at any time by providing written notice to Midwest Neurosurgery & Spine Specialists. This authorization will expire on _____ or 1 (one) year after the date signed.

Signed: _____ Date: _____
Patient/Legal Guardian

Witness: _____ Date: _____

MIDWEST NEUROSURGERY

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