

Authorization of Release of Medical/Billing Information

I, _____ hereby authorize and direct Collier Spine Institute, or its authorized representative, to furnish medical / billing information that may concern myself with respect to any injury or illness, medical history, consultations, prescriptions, treatment, or hospital records, including, but not limited to, x-ray studies, diagnostic procedures, or other medical records.

It is my understanding that if these records should include information relating to any HIV testing for the AIDS antibody, drug or alcohol use / abuse and treatment, or psychiatric / psychological evaluations and treatments, unauthorized disclosure of this information to any third party is prohibited by state and federal statute. I hereby specifically authorize the release of medical / billing information to the following parties:

| | | |
|------|--------------|--------------|
| Name | Relationship | Phone number |
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| Name | Relationship | Phone number |
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| Name | Relationship | Phone number |
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|--------------|---------------|
| Patient Name | Date of Birth |
|--------------|---------------|

| | |
|-------------------|------|
| Patient Signature | Date |
|-------------------|------|

Or

Signed by: _____ (legal representative or guardian)