

# COLLIER SPINE INSTITUTE

## AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, \_\_\_\_\_ DOB \_\_\_\_\_ hereby authorize and direct Collier Spine Institute, or its authorized representative, to furnish copies of any and all medical records it may have concerning 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, Sexually Transmitted Diseases (STD's), drug or alcohol use/abuse and treatment, or psychiatric/psychological evaluations and treatment, unauthorized disclosure of this information to any third party is prohibited by state and federal statute. I hereby specifically authorize the release of these records to the following parties and release Collier Spine Institute from any and all liability arising therefrom:

To: \_\_\_\_\_

Via: Mail to the following address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**OR**

Signed By: \_\_\_\_\_  
Parent or Natural Guardian

of \_\_\_\_\_  
A Minor Child

**A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE AS EFFECTIVE AS THE ORIGINAL**

COLLIER SPINE INSTITUTE

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