Spine Institute of Idaho
360 E. Montvue Drive Ste 100
Meridian, ID 83642
Phone:(208) 898-9907
Fax: (208) 898-9877

Patient Information Release Authorization

Name of Facility: ____
(Where the records are going)

Address of Facility____

Phone Number:____________________________

Name of Patient: __________________________________ **DOB:** ______________

Phone: _______________________________ **Fax:** _________________________

Address of Patient: ____
____
____

Please choose one:

- ❑ I hereby authorize the Medical Information Department of Spine Institute of Idaho the right to release information contained in my patient records to the above requestor.
- ❑ Please send the requested information from the above facility to Spine Institute of Idaho.

Please choose the type of information to be disclosed:

- ❑ Patient Chart
- ❑ Test Results
- ❑ X-Ray Films
- ❑ Other ____

____
Signature of Patient or Legal Guardian **Date**

Comments____
____

(Without expressed revocation by patient or guardian this consent shall be effective for 90 days)

FOR OFFICE USE ONLY
Patient to pick up records: YES / NO Date to be picked up ____________________
Date picked up_________________ Request completed by___________________