THE TEXAS
BRAIN AND SPINE
INSTITUTE

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Authorization for Release of Information

Jonathan A. Friedman, M.D.
Jason M. Hoover, M.D.
L. Gerard Toussaint III, M.D.
J. Bradley White, M.D., Ph.D.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

I _____ (Print Name of Patient/Individual) hereby authorize

CHI St. Joseph Regional Health Center – TBSI Neurosurgery to use and disclose the protected health information as described below to the following person(s) or organization:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Purpose of Disclosure:

__ Continuity of Care __ Transfer of Care __ Legal

__ Insurance __ Personal Use __ Other: _____

The following information may be used and/or disclosed:

___ Complete Medical Record and /or ___ radiology CD's of any treatment or examination

Signature: _____ Relationship to Patient: _____ Date: / /

This authorization will expire 1 year from the date signed unless the facility receives a Revocation. I understand that I may revoke this authorization at any time by notifying the facility in writing.

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.