

RELEASE OF MEDICAL INFORMATION

I, _____, give permission to The Spine and Neuro Center to release information regarding medical care at this office, including my prescriptions, my appointments, and other medical information to the following people. I also give my permission for messages to be left on the answering machine at my home phone.

| Name | Relationship | Phone Number |
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I understand that every effort will be made by The Spine and Neuro Center to contact me with this information but in order to provide me with the best medical care possible, it may be necessary, in my absence, to give information to others. This release will remain in effect indefinitely or until revoked by me.

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| Patient's Signature | Date |
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DISCLOSURE:

THE SPINE AND NEURO CENTER FULLY DISCLOSES THAT OUR PHYSICIANS AND STAFF MAY INVEST AND/OR PARTICIPATE WITH CLINICAL RESEARCH STUDIES, PRODUCT DESIGN PROJECTS, MEDICAL DEVICE MANUFACTURERS AND HEALTHCARE SERVICE PROVIDERS, WHEREBY REMUNERATION FOR TIME AND EXPERTISE IS USUAL AND CUSTOMARY. EXAMPLES OF CORPORATIONS THAT THE SPINE AND NEURO CENTER STAFF AND PHYSICIANS MAY INVEST AND/OR PARTICIPATE WITH INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: MEDTRONIC SOFAMORE-DANEK, SYNTHES SPINE, KYPHON, BIOIMAGING, GLOBUS MEDICAL, SURGERY CENTER OF HUNTSVILLE, NEW CENTURY PHARMACEUTICALS, ET CETERA.

IF YOU GRANT PERMISSION ABOVE, PLEASE DO NOT COMPLETE THE REST OF THIS FORM. IF YOU WISH TO DENY ACCESS OF YOUR MEDICAL RECORDS TO ANYONE, PLEASE COMPLETE THE FOLLOWING.

I, _____, **do not** grant The Spine and Neuro Center my permission to leave any medical information with anyone other than myself, my family physician, and/or referring physician.

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| Patient's Signature | Date |
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