



Authorization to Disclose Information

I, _____ authorize and permit Rocky Mountain Brain & Spine Institute to disclose the following medical information: (check all that apply)

- Services rendered at this office (including participation in research studies)
- Last office visit, laboratory and/or imaging test results
- Information regarding mental illness, substance abuse, or infectious diseases
- Medications prescribed
- Scheduled appointments / telephone confirmation of appointments on answering machine
- Billing Statements / Correspondence from this office
- Email correspondence
- Other (Please Specify)

To the following family member or person listed below:

Name: _____ Relationship to Patient: _____ Phone # _____

Name: _____ Relationship to Patient: _____ Phone # _____

This authorization is effective _____ and shall continue to be effective until otherwise revoked in writing by me. If you wish to revoke this authorization, you must do so in writing to your physician at Rocky Mountain Brain & Spine Institute. If you choose to revoke this authorization, it will become effective upon receipt but will not apply to disclosures previously made with your consent.

My signature below acknowledges that a copy of the privacy practices followed at Rocky Mountain Brain & Spine Institute is available to me upon request.

Patient Name: _____ Date of Birth: _____

Signature: _____ Social Security # _____

Or Power of Attorney: _____