ADVANCED SPINE AND BRAIN CENTER
An affiliate of Liberty Hospital

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Permission to Disclose Information to Those Involved in My Care

This form does not authorize releasing copies of my medical records.
To the following people who are involved with my healthcare and/or payment information:
(check all that apply and list names and telephone numbers)

- ☐ Spouse_____ Phone:_____
- ☐ Friend_____ Phone:_____
- ☐ Child(ren)_____ Phone:_____
- ☐ Other_____Phone:_____
- ☐ Do not release my information to anyone.

I hereby allow Advanced Spine and Brain Center to disclose the following information.
(check all that apply)

- ☐ Appointment times and dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Tests that have been performed
- ☐ Test results
- ☐ Billing/payment information
- ☐ Other health information (describe)_____

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail? (check how you wish to receive messages, and provide the phone number)

- ☐ No, DO NOT leave any messages
- ☐ Yes, at home, cell phone or work:
  Home Phone:_____Cell Phone:_____Work Phone:_____
- ☐ Yes, only at home Home Phone:_____
- ☐ Yes, only on cell phone Cell Phone:_____

I understand that in certain situations Advanced Spine and Brain Center may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permission at any time.

Patient Name (please print):_____ Date of birth:_____

Patient/Guardian Signature:_____Date:_____

If patient is a minor, please complete the following information:

Mother's name/contact number:_____

Father's name/contact number:_____