MINIMALLY INVASIVE BRAIN AND SPINE

Toll Free (800) 323-6427
Local (281) 652-5500
Fax (713) 664-4488

Authorization to Release Information to Family Members

Name of Patient: _____

Date of Birth: _____

I hereby authorize medical providers and personnel of Minimally Invasive Brain and Spine to discuss my protected health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The authorization shall effective from _____ to _____ at which time authorization to disclose protected health information will expire.

- Unless specified above, this authorization expires 365 days from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I have the right to refuse to sign this authorization.

_____ _____

Patient Signature Date

_____

Patient Printed Name