LANCASTER
NEUROSCIENCE
& SPINE ASSOCIATES

&
The Center For Spine Care

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I,_____ (patient), Date of Birth _____ request and authorize disclosure of the following health information:

FROM: Lancaster NeuroScience & Spine Associates (LNSA) and The Center for Spine Care (CSC)

TO:_____

ADDRESS: _____

_____
Physician name and complete address required

My protected health information, including all written and oral reports, substantive evaluation of progress, history, diagnosis, prognosis, course of treatment, reports and attendance and compliance with respect to all care or treatment, including all confidential HIV and AIDS related information, mental health records, drug and alcohol abuse treatment records, child abuse information, and records of sexual abuse and assault counseling.

I consent to the release of this confidential information and I understand that:

1. I may revoke this authorization at any time in writing to: LNSA/CSC
   Attn: Privacy Officer
   1671 Crooked Oak Dr.
   Lancaster, Pa. 17601
   A revocation will not impact any action taken prior to our receipt of the revocation in reliance on this authorization.
2. This authorization shall be in effect: _____ until I revoke authorization
   _____ expiration date or event
3. The purpose of this disclosure is _____

   _____

I, _____ (patient) understand that the information contained in my medical records is confidential information protected by federal and state law. I understand that by signing this release, I consent to the release of my confidential medical information. I, agree to indemnify, defend, and hold harmless Lancaster NeuroScience & Spine Associates/ The Center for Spine Care, its agents, servants, employees, assigns, successors in interest, attorneys, and insurance carriers from and against all claims, losses, liabilities, damages, expenses, costs, including attorneys• fees, which may arise as a result of or are in any manner related to improper disclosure of patient medical records.

_____ _____
Signature of patient or personal representative Date of Receipt

If the above signatory is a personal representative, please state relationship to the patient:

_____ _____
Relationship to patient (or other authority) Printed Name of Representative