CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

_____ (initials) I have read and acknowledge Cameron Spine's Notice of Privacy Practices. Cameron Spine complies with all regulatory guidelines with regard to safeguarding your protected health information(PHI). For example, sharing of my PHI may only occur between authorized entities such as my insurance company and my physicians, but not my spouse. These guidelines and our polices are published in this Notice. A copy for my records will be provided at my request.

_____ (initials) I authorize my primary care physician, referring physician and other care providers to furnish any and all information concerning my present illness or injury to Cameron Spine

_____ (initials) I authorize Cameron Spine to leave information and appointment reminders at the following:

□ Home Phone: _____ □ Work phone: _____

□Cell Phone: _____ □ email address: _____

Please list any authorized entities with who we can share your PHI:

□ NONE

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

_____ _____

Patient Name (Please Print) Patient DOB

_____ _____

Patient Signature Date Signed

_____ _____

Guarantor Signature (if different than patient) Date Signed