midtown
PAIN AND SPINE CLINIC

A division of Eastern Carolina Anesthesia Associates

Authorization for Disclosure of Protected Health Information

Patient Name: _____ Med.Rec.#: _____
Phone: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____

I hereby authorize _____
(name/address of person/organization to release records from)
to release information from the medical records of _____
(patient name)
to: Dr. Thomas Weber, Midtown Pain and Spine Clinic
(name/address of person/organization to which disclosure is to be made)

Fax #: **(984) 272-3917** Phone #: **(984) 272-4028**

For treatment dates: _____

For the following purpose: Medical Care (continuing care)

- ☐ Entire record including, but not limited to diagnoses, lab and imaging results, and treatments.
- ☐ Entire record excluding HIV & chemical dependency
- ☐ Entire record excluding mental health records
- ☐ Other

This authorization expires 180 days from the date signed below and covers only treatment(s) for the dates specified above.
I, the undersigned, have read the above and authorized the disclosure such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in the reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the receipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____
Date Signature of patient/parent/guardian