

## Policy for Completing Medical/Disability Forms

- Medical/Disability forms are completed for a \$25.00 fee per form.
- A signed medical release of information from Carolina Back Institute must accompany any medical form requiring completion.
- Payment and a signed medical information release must be received with the form at the time the request is made. Without payment, the form will be returned to the patient uncompleted.
- We request the original form. No faxed or photocopied forms will be accepted.
- Forms cannot be completed during an office visit.
- Patients must have been seen by a Physician at Carolina Back Institute within 6 weeks prior to submitting form.
- Completed forms will be mailed to the patient's home address within two weeks.

## Authorization for Release of Medical Information

PRINT PATIENT'S FULL NAME \_\_\_\_\_

BIRTH DATE (MO/DAY/YR) \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

CITY, STATE, ZIP CODE \_\_\_\_\_

PHONE (HOME) \_\_\_\_\_

I authorize **Carolina Back Institute** to disclose the following information from my health record:

Information to be used or disclosed for the purpose of review and/or examination:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> DISCHARGE SUMMARY  | <input type="checkbox"/> PATHOLOGY REPORTS   | <input type="checkbox"/> EMERGENCY REPORTS |
| <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> LABORATORY REPORTS  | <input type="checkbox"/> OTHER _____       |
| <input type="checkbox"/> PROGRESS NOTES     | <input type="checkbox"/> RADIOLOGY REPORTS   | _____                                      |
| <input type="checkbox"/> OPERATIVE NOTES    | <input type="checkbox"/> ECG/EEG/CARDIC CATH | _____                                      |

**Carolina Back Institute will not release records sent from other Medical Providers**

I do  I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV(Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, or treatment for alcohol and/or drug abuse.

### INFORMATION RELEASE TO:

1. NAME:

2. NAME:

ADDRESS:

ADDRESS:

### PURPOSE OF DISCLOSURE:

- |   |   |                                       |   |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> REFERRAL TO SPECIALIST | <input type="checkbox"/> INSURANCE                | <input type="checkbox"/> WORKERS COMP | <input type="checkbox"/> CHANGE OF DOCTOR |
| <input type="checkbox"/> LEGAL INVESTIGATION    | <input type="checkbox"/> DISABILITY DETERMINATION | <input type="checkbox"/> PERSONAL     | <input type="checkbox"/> CONTINUING CARE  |
| <input type="checkbox"/> OTHER(SPECIFY) _____   |   |                                       |   |

Please provide current telephone number in the event we need to contact you: \_\_\_\_\_

This authorization will expire on \_\_\_\_\_ ( Date or Event )

If I fail to specify an expiration date or event, this authorization will expire 12 months from the date of signature.

I hereby authorize disclosure of the health information for the above named patient. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the health information management department. I understand that revocation will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that the medical provider to whom this is authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
Signature of individual or guardian or  
Personal Representative of patient's estate

\_\_\_\_\_  
Date

\*\* MEDICAL/DISABILITY FORMS ARE COMPLETED FOR A \$25.00 FEE PER FORM.

**\*\* NOTE: THERE WILL BE A CHARGE FOR RECORDS. \$0.75 A PAGE FOR THE FIRST 25 PAGES, \$0.50 THEREAFTER WITH A MAXIMUM OF \$25.00 PER REQUEST PLUS POSTAGE WHEN REQUESTING RECORDS FOR PERSONAL USE OR PERMANENT TRANSFER. SMART CORPORATION HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. QUESTIONS CALL 1-800-822-1665.**

### MEDICAL INFORMATION RELEASED BY SMART CORPORATION

- |                                 |                                |                                      |                |
|---------------------------------|--------------------------------|--------------------------------------|----------------|
| <input type="checkbox"/> ENTIRE | <input type="checkbox"/> LAB   | <input type="checkbox"/> EKG         | _____          |
| <input type="checkbox"/> DS     | <input type="checkbox"/> EKG   | <input type="checkbox"/> IMMUNE      | ROI SPECIALIST |
| <input type="checkbox"/> OP     | <input type="checkbox"/> X-RAY | <input type="checkbox"/> OTHER _____ | _____          |
| <input type="checkbox"/> HP     | <input type="checkbox"/> PATH  | _____                                | DATE           |
| NUMBER OF PAGES _____           | _____                          | _____                                | _____          |