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I hereby authorize SPINE INSTITUTE OF LOUISIANA to obtain or release any and all private health information concerning my care from any physician, hospital, or other health care provider providing medical care to me at any time for the purposes of treatment, payment or health care operations and that SPINE INSTITUTE OF LOUISIANA will not condition treatment, payment, enrollment or eligibility on whether I sign this authorization. I understand that I or my legal representative may revoke this authorization at any time by written request. I also understand that any information disclosed may be subject to re-disclosure by the recipient and no longer under the control of the SPINE INSTITUTE OF LOUISIANA. I understand that the information released/obtained may contain information regarding psychiatric treatment, HIV/AIDS treatment, or alcohol/substance abuse treatment.

PATIENT NAME: _____

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X _____
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This authorization expires one year from the above date

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(OFFICE USE ONLY)
FACILITY/DOCTOR:

SPECIFIC REQUEST: _____ MEDICAL RECORDS _____ X-RAY REPORTS _____ LAB

_____ FILMS _____

_____ OTHER _____

FOR DATES _____