SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

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Relative Authorization

Patient Name:_____ **Date of Birth:**_____ **MR#**_____

1) **I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.**

Authorized Designees:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Privacy/Appointment Reminders

To be able to communicate your scheduled upcoming treatments, any relevant co-payment information, or any important medical information or finding(s), it is important to be able to have your best contact number, and authorization to contact you to leave a message on your voicemail at a specified phone number and/or to notify you of any important information as needed.

Do we have your permission to leave information on your HOME/CELL answering machine/voicemail regarding:

Appointment Information?	☐ **Yes**	☐ **No**
Billing Information?	☐ **Yes**	☐ **No**
Medical Information?	☐ **Yes**	☐ **No**

If yes, please provide the phone number(s) you would like us to use to leave this information

_____ **Please circle: Home / Cell** _____ **Please circle: Home / Cell**

_____

Patient Signature **Date**