Please fax records back to: 904-330-0418

JACKSONVILLE
BRAIN & SPINE

Cranial and Spinal Surgery

Patient Name: _____ **DOB:** _____

Address: _____

City/State/Zip: _____

Phone: _____

☐ I authorize Jacksonville Brain and Spine, PLLC to ***SEND*** my medical information to:
Name of Provider/Facility: _____
Address: _____
Fax: _____

☐ I authorize Jacksonville Brain and Spine, PLLC to ***REQUEST*** my medical information from:
Name of Provider/Facility: _____
Address: _____
Fax: _____

Records Requested:
☐ Visit Notes
☐ Radiology/Imaging
☐ Treatment records

Purpose of this request:
☐ Continued care
☐ Transfer of care

I understand that:
I have the right to inspect and receive a copy of the health information and there may be a charge for copies. I release Jacksonville Brain and Spine, PLLC and it's employees from any liability that may arise from the release of information that I have directed. I understand that I have the right to revoke this authorization at any time and it must be in writing.

Printed Name _____ Signature _____
Date _____

Jacksonville Brain and Spine, PLLC
7807 Baymeadows Road East, Ste 208
Jacksonville, FL 32256
PH: 904-330-0302
Fax: 904-330-0418