

I authorize the release of all necessary records and reports to:

Dr. Elizabeth Baker

Dr. Nora Taha

Dr. Lauren Terranova

Spine Center & Orthopedic Rehabilitation of Englewood, PC

106 Grand Avenue, Suite 220

Englewood, New Jersey 07631

(201) 503-1900

Please fax to: (201) 503-1901

I understand that the records you release may contain information pertaining to the following:

Consultations/examinations

Mental health information

Results of diagnostic testing

Diagnosis of sexually transmitted diseases

Drug and alcohol abuse information

I understand that if I do not want any of the above information released, I may limit your authorization to release such information by crossing it out and initialing it. If there is other information that I specifically do not want released, I should identify it in the following space: _____ (if none, write none.)

Right to Revoke Authorization: I understand that I may revoke this authorization at any time by notifying you in writing at the address set forth on this page. I understand that if you have already released information or otherwise acted in reliance upon this authorization, that any subsequent revocation will affect the validity of your prior disclosure or other action. I also understand that if this authorization was provided for purpose of obtaining insurance coverage, my revocation might give rise to the insurer's right to contest a claim and/or to contest the validity of any insurance issued in reliance of the authorization.

Termination: If not revoked by me sooner, this authorization will terminate six months from the date of signature.

Right to inspect Information: I understand that I have the right to inspect the information to be disclosed.

Name

Signature

Date of Birth

Date

Relationship to person whose records are sought