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COVENANT
SPINE AND NEUROLOGY

Alexander K. Powers, MD, FAANS
Allyson Bryant, MD
Andreas Runheim, MD
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Authorization for Use and Disclosure of Protected Health Information

I consent to and authorize: _____
Person(s) or institution authorized to release the information

_____
Address City State Zip

To release to: Covenant Spine and Neurology, PLLC
(person(s) or institution receiving the information)

_____
Address City State Zip

Description of Information that may be used or disclosed:
(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse and/or HIV/AIDS, if applicable)

- ○ Medical Information from the most recent visit/admission to include physician notes/summaries and diagnostic results
- ○ Medical information including physician notes/summaries and diagnostic results for the periods from _____ to
- ○ Other: Specific information to release _____

For the periods from _____ to

Please circle the reason for request: Treatment, Insurance, Legal, Other:

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____