INNOVATIVE
SPINE CARE

10903 Sheldon Road • Tampa, FL 33626
Phone: 813-920-3022 • Fax 813-920-3002

www.GotSpinePain.com

(Please Print Clearly)

Medical Records Release Form

In order to avoid a delay this form must be completed in its entirety.

Patient Name:_____ Maiden Name:_____

D.O.B. (Required)_____ SS#(Required)_____

Home Phone:_____ Work Phone: _____

Permission is hereby granted to Stephen Watson, MD PHD to release medical information to the individual / organization as noted below or to have records released to Stephen Watson, MD PHD:

Mail to:
Name:_____

Address:_____

City:_____ State: _____ Zip: _____

Fax to another medical entity | Call when ready for pick up | Person picking up records

(____)_____ (____)_____ _____

Please check information to be released:

- ☐ All records, excluding records from other physicians.
- ☐ Surgical Records
- ☐ Therapy reports
- ☐ Diagnostic test results
- ☐ Other _____
- ☐ Office Notes only
- ☐ X-ray/MRI films
- ☐ X-ray/MRI reports
- ☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner._____
Date

I understand I have the right to refuse this authorization, in writing, and Stephen Watson, MD PHD is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date