THE NEUROLOGICAL INSTITUTE of SAVANNAH & CENTER FOR SPINE

Medical Release Authorization

Patient's Full Name	Patient's Social Security Number/Medical Record Number
Address	Patient's Date of Birth
City, State Zip Code	Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following facility/physician may receive disclosure of protected health information about me:

Neurological Institute of Savannah , Dr. Davis Reames
Company/Physician

4 E Jackson BLVD Savannah, GA 31405
Address

912-721-0208 Fax # 912-503-2975
Phone/Fax

2. Effective Period

This Authorization for release of information covers the period of healthcare from:

☐ _____ to _____

OR

☐ All past, present, and future periods.

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION * _____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**