



Lee Ann Brown, D.O  
Jessica Herrington, ARNP

**Authorization for Release of Medical Information**

(Please Print)

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- I hereby authorize SpinePain & Orthopedic Injury Center to release any information in my chart to any medical practitioner, doctor, hospital, or medical institution/facility to which I may be referred to assist with my care.
- Additionally, I authorize SpinePain & Orthopedic Injury Center to obtain any medical information from any medical practitioner, doctor, hospital, or medical institution/facility to assist in my care.

Signature of Patient, Guardian, or Personal Representative:

\_\_\_\_\_

Date: \_\_\_\_\_

Thank you for choosing SpinePain & Orthopedic Injury Center to provide your medical care.

Phone (727) 210-2225 Fax (727) 210-0880