New York Spine & Wellness Center

Attention Medical Records
5496 East Taft Road, North Syracuse, NY 13212

PERMISSION FOR COMMUNICATION

Patient Information (Please Print)

Name: Last First Middle **Date of Birth**

Address: Street Address City State Zip Code

I permit New York Spine and Wellness Center, their physicians, nurses and other personnel to discuss my health information, in person or by telephone, or via electronic communication with the following family members or friends; (List family members /friends and state the relationship to the patient).

Medical Information

Name	Phone Number	Relationship
1.		
2.		
3.		

Behavioral Health Information

Name	Phone Number	Relationship
1.		
2.		
3.		

Release of information under this document is limited to verbal discussions, and electronic communication. This document does not permit release of records.

This authorization is limited to the following time frame from _____(date) to _____(date). If no dates are indicated, this form will remain in effect for an unlimited amount of time or until it is revoked in writing.

If, at any time I do not want communication of any form to be permitted between NYSWC and any individuals named above, I must notify NYSWC by contacting my provider.

_____ _____
Signature of Individual Date

If this Authorization is to be signed by a Personal Representative of the Individual, please complete the following:

_____ _____
Signature of Personal Representative Printed Name of Personal Representative Date

Description of authority: _____
(A personal representative must provide legal proof of representation, e.g., guardian, health care proxy, Power of attorney)