Comprehensive Spine Center
Julian A. Cameron, M.D.
Authorization to Discuss Medical Information

I hereby authorize you to use or disclose my medical condition/treatment/appointments/surgery/Misc. information to the parties listed below.

Patient Name: ____

Date of Birth: ____

Information to be given to:

Name: ____

Relationship: ____

Phone: ____

Name: ____

Relationship: ____

Phone: ____

This authorization shall remain in effect from the date signed below until (please check one):
□ NO EXPIRATION DATE
□ (specify expiration date or event) ___________________________
I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting Comprehensive Spine Center, attention Medical Records.
- This authorization is giving Comprehensive Spine Center the right to discuss my medical information with the one or more people listed above.
- I may refuse to sign this authorization and Dr. Cameron will not condition treatment on my providing this authorization

Signature: ____ **Date**: _________________