Select Health of the Carolinas
Herniated/Degenerative Discs * Sciatica * Neuropathy * Joint Issues * Nutrition

THE DISC INSTITUTE

I authorize you to use or disclose my health information in the manner described on the following forms:

-Consent for Use of Disclosure of Health Information
-Appointment Reminders and Health Care Information Authorization
-In-office Recognition/Correspondence by Mail/Fax/Electronic Communication

I am also acknowledging that I am aware that a copy of the above listed authorizations/consents is available to me upon my request.

I authorize my health information to be shared/released with/to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____ / _____ / _____
Patient Name Printed Date

_____ _____
Patient signature Authorized provider representative

_____ _____
Personal representative printed Personal representative signature

_____
Description of personal representative's authority to act for patient