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Joseph P. Sullivan, MD
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HARBORSIDE Spine & Sports Center
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2375 Summit Park Drive
Petoskey, MI 49770
Phone: 231-348-3283
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Authorization for Release of Protected Health Information

Patient's Name _____ Date of Birth _____

Address _____ City, State, and Zip Code_____

Phone #1 _____-_____-_____ Phone #2 _____-_____-_____

I hereby authorize:

- ☐ Harborside Spine and Sports Center
- ☐ Physician's or Office Name _____

  Address _____ City, State, and Zip Code_____

  Phone _____-_____-_____ Fax _____-_____-_____

To release my confidential health information, as described below, to:

- ☐ Myself
- ☐ Harborside Spine and Sports Center
- ☐ Physician's or Office Name _____

  Address _____ City, State, and Zip Code_____

  Phone _____-_____-_____ Fax _____-_____-_____

In the following manner:

- ☐ Copies by mail ☐ Copies to be picked up
- ☐ Copies by fax ☐ Other: _____

My authorization is for the use and disclosure of the following records:

- ☐ Medical Records Date _____
- ☐ Lab Reports Date _____
- ☐ X-Rays and Report of _____ Date _____
- ☐ CT Scan and Report of _____ Date _____
- ☐ MRI and Report of _____ Date _____

Patient's Signature _____ Date _____

Witness Signature _____ Date _____

Provider Initials_____