

SOUTH SHORE NEUROSPINE GROUP, LLC



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AUTHORIZATION TO FURNISH MEDICAL INFORMATION

This authorizes the physicians of South Shore NeuroSpine Group, LLC, to release to any hospital and all medical attendants involved in my care, full and complete reports and information that may be requested by and/or to any of those entities.

This authorization also includes examination and/or release of all hospital or office records, MRI films, x-ray films, tests, test results, and any other written documentation related to my medical care.

Additionally, South Shore NeuroSpine Group, LLC is authorized to release any and all information compiled by them relevant to my continued medical care that may be requested of them after services have been provided.

A photocopy of this authorization may be accepted with the same authority as the original.

Unless specifically terminated, this consent will extend for an unlimited period of time while the below signed individual is under the care of South Shore NeuroSpine Group, LLC.

Patient Signature

Date

Printed Name