NeuroSpine Institute

AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF HEALTHCARE RECORDS

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

DATES OR TYPE OF INFORMATION TO RELEASE: DATES:_____

SPECIFIC INFORMATION REQUEST:_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be released if I place my initials in the applicable space next to the type of information:

____By initialing here, I specifically consent to the disclosure of my HIV/AIDS information

____By initialing here, I specifically consent to the disclosure of my mental health information.

____By initialing here, I specifically consent to the disclosure of my genetic testing information

____By initialing here, I specifically consent to the disclosure of my drug/alcohol diagnosis, treatment or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

RELEASE TO/FROM: _____(___) PATIENT

ADDRESS:_____

CITY, STATE, ZIP_____

PHONE: (_____)_____ FAX: (_____) _____

PURPOSE OF THE RELEASE:_____

FORMAT RECORDS ARE TO BE RELEASED: (_____) MAIL (____) FAX (___) PICK UP AT OFFICE (___) INCLUDE IMAGING CD

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing AUTHORIZATION FOR RELEASE OF INFORMATION and so hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient or Authorized Representative: _____

Relationship to Patient_____ Date:_____

****PLEASE NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS****