AUTHORIZATION FOR RELEASE OF INFORMATION

Spine & Orthopedic Center

Patient Name

Address: City State Zip code

Phone: Disclosure Reason:

Name of Recipient: Phone: Fax:

Address: City State Zip code

Date(s) of Treatments Being Disclosed: From: To:

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected by federal regulations.

Patient Name: Social Security Number:

Date of Birth: Medical Records # (if Known:)

Name of Facility and/or Person That is Releasing My Records:

Person(s) Receiving My Health Information:

Description of Information Being Disclosed:

- ☐ Complete Health Record
- ☐ Radiology Reports
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ History and Physical Exam
- ☐ Abstract/ Pertinent Information
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Emergency Department Record
- ☐ HIV/ AIDS Information
- ☐ Drug/ Alcohol Treatment Information
- ☐ Other: _____

Purpose of Disclosure:

Example: " At the Request of the Patient."

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization will expire in 60 days. Otherwise, select either of the following expiration events:

- ☐ 1 year from the date in which I or my legal representative sign this authorization.
- ☐ Upon happening of the following events: _____

Right to revoke: I understand that I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care. I understand that my revocation won't have any effect on any action taken by this organization before they receive the renovation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage. The insurer has the legal right to contest a claim under my insurance policy.

I understand that the organization will not condition my treatment, payments, enrollment in a health plan, or eligibility for benefits on my signing this authorization. I understand that i have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.
TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above: ☐ YES ☐ NO

Patient Signature _____ Date: _____

If signed by the patient's legal representative:
Printed name of representative:_____Relationship to the patient_____