



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Release Information from:**

I request and authorize (records from):

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Send Records to:**

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Description of Protected Health Information to be disclosed:**

- Complete Medical Record                       Urine Drug Screens                       Lab Tests  
 All diagnostic reports (EMG, CT, MRI, X-ray)     Other: \_\_\_\_\_

**Purpose(s) of the disclosure:**

- Continuity of Care                       Transfer of Care                       Personal Use  
 Second Opinion                       Supplemental Care                       Legal  
 Insurance Coverage or Payment of Care     Other: \_\_\_\_\_

I hereby authorize Provider to release Protected Health Information ("Information") to Advanced Spine and Pain. I understand that this authorization may cover information relating to: (i) AIDS, HIV and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental and behavioral health and treatment; and (iv) alcohol, drug and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before and revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eight (180) days following the date of execution. I understand that a photocopy of facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.