ADVANCED
SPINE AND PAIN

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 Patients Legal Representative Date

_____

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