SPINAL DIAGNOSTICS

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AUTHORIZATION TO OBTAIN & DISCLOSE HEALTH INFORMATION

I authorize the use or disclosure of the individual's health information named below to be used or disclosed as follows:

Patient Name: _____

Alias or Other Names: _____

Date of Birth: _____

Please **OBTAIN** information **FROM** the following:

_____
Name & Title of Provider/Organization Name

_____
Street Address (or specific fax number)

_____
City/State/Zip (This information must be provided)

Please **SEND** my health information **TO**:

_____
Name & Title of Provider/Organization Name

_____
Street Address (or specific fax number)

_____
City/State/Zip (This information must be provided)

For the purpose of: [ ] Patient Care[ ] Self/Personal Records [ ] Other: _____

DESCRIPTION OF NATURE OF INFORMATION TO BE USED AND/OR DISCLOSED:

[ ] Most recent 2yrs of records [ ] Clinician office notes [ ] History & Physical Exams

[ ] X-ray & imaging reports [ ] Consultations [ ] Lab reports [ ] All Clinic records [ ] Billing statements

Records for the following dates of treatment: _____

[ ] Other (specify):_____

List specific dates of records to be released: _____

THE FOLLOWING (*) MUST BE *INITIALED* BY THE PATIENT TO BE INCLUDED IN THE USE AND/OR DISCLOSURE OF OTHER HEALTH INFORMATION:

_____*HIV/AIDS related information and/or records _____*Mental Health information _____*Psychotherapy notes

_____*Genetic Testing information _____**Drug/Alcohol information

**Federal regulation requires a description of how much and what kind of information will be disclosed.

DURATION: This authorization shall begin immediately and remain in effect until notified otherwise.

RESTRICTIONS: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by privacy laws or regulations.

RIGHTS: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy and Spinal Diagnostics has up to 30 days to comply with my written request. I understand that I have the right to revoke this authorization by sending a written statement to the clinic manager of the disclosing location listed above. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signed:_____ Date: _____

(*Patient or Legal Representative)*

If signed by legal Representative, name & relationship to patient: _____

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