

Robert D. Heros, M.D. * Jason G. Anderson, D.O. * Tyler G. Huntington, PA-C * Ayumi Mizuno, AGNP-C

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: Please **SEND** my health information **TO**: Name & Title of Provider/Organization Name Name & Title of Provider/Organization Name Street Address (or specific fax number) Street Address (or specific fax number) City/State/Zip (This information must be provided) 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: [] 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: (Patient or Legal Representative)

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