SPINE INSTITUTE OF ARIZONA

9735 NORTH 90TH PLACE
SCOTTSDALE, AZ 85258
TEL 602/953.9500 FAX 602/953.1782

Authorization for Spine Institute of Arizona to Use or Disclose My Health Information

Patient Name: ____________________ SIA Physician: ____________________
Address: ____________________ Date of Birth: ____________________
____________________ Telephone: (Day) ____________________
Social Security # ____________________ (Home) ____________________

THIS AUTHORIZATION EXPIRES: ❐ **ON (DATE)** ____________________

*Per HIPAA Regulation an authorization for disclosure of Protected Health Information **MUST** have an expiration date. Your expiration date may not exceed six years from the initial date of authorization.*

I. My Authorization- You may use or disclose the following health care information (check all that apply):

❐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavorial Health Care/Psychiatric Care / Psychotherapy Notes, Alcohol and/or Drug Abuse Treatment ____________________

❐ All radiologic studies in Spine Institute of Arizona's possession. *(I understand and agree that I am financially responsible for the following fees associated with my request: I understand that there is a copying charge of **$7.00 per x-ray** for my Spine Institute of Arizona x-rays films.)*

❐ All of my health information except the following: ____________________

II. Disclosure of My Health Information

❐ **Copies of my health information** ❐ **Inspection** *(I agree not to make any marks on or alter the record in any way and understand an office representative will be present.)*

TO: Name and / or Organization: ____________________
Address: ____________________
City: ____________________ State: ____________________ Zip Code: ____________________
Phone: ____________________ Fax: ____________________

You may disclose this health information by: ❐ **Mail** ❐ **Fax** ❐ **Patient Pickup**

❐ **Spine Institute of Arizona may receive my health information by mail or fax from:**

Physician/Facility: ____________________
Address: ____________________
City: ____________________ State: ____________________ Zip Code: ____________________
Phone: ____________________ Fax: ____________________

Reason(s) for this authorization (check all that apply):

❐ at my request ____________________
❐ other (specify) ____________________
❐ check here only when (physician or clinic) requests the authorization for marketing purposes
❐ check here only when (physician or clinic will get something of value for providing health information for marketing purposes

III. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a dated letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect it.

I understand that is this office has requested this authorization, I have a right to inspect or copy the information to be used or disclosed.

____________________ Patient or legally authorized individual signature
____________________ Date

____________________ Printed Name if signed on behalf of patient
____________________ Relationship (parent, legal guardian, personal representative, etc.)

To Karen	*Completed*

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