

Patient Name: _____ SIA Physician: _____
 Address: _____ Date of Birth: _____
 Social Security # _____ Telephone: (Day) _____
 (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, Behavioral 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