SPINE INSTITUTE
of Arizona

AUTHORIZATION FOR SPINE INSTITUTE OF ARIZONA TO USE OR DISCLOSE MY MEDICAL INFORMATION

Entity Releasing Information	
Facility:	
Address:	
City, State	Zip Code
Fax:	Phone:

Entity Receiving Information	
Entity/Individual:	
Address:	
City, State	Zip Code
Fax:	Phone:

Patient Information:	Patient Name:_____ Date of Birth: _____ Address:_____ Phone Number: _____ _____ SSN: _____
Dates Requested:	FROM:_____ TO:_____

There May be a FEE Associated with your Request for Records

Records Being Requested:	☐ 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: _____ _____ ☐ **Other Records:** ☐ Billing Record 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 form the initial date of authorization.*
Delivery of Records:	**Paper Requests** ☐ Mail ☐ Pick Up ☐ Fax **Electronic Requests:** ☐ Patient Portal ☐ CD **(Complete ONLY if requesting records via Patient Portal)** **Email Address for Patient Portal**
Purpose:	☐ Self ☐ Continuing Care ☐ Other (please specify):_____

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 receive s it may re-disclose it, as privacy laws may no longer protect it.

I understand that 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)