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: _____<br>Address:_____ Phone Number: _____<br>_____ 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):<br>☐ 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<br>☐ 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.)<br>☐ All of my health information except the following:<br>_____<br>_____<br>☐ **Other Records:** ☐ Billing Record |
| | THIS AUTHORIZATION EXPIRES ON DATE:_____<br>*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** ☐ Pick Up ☐ Fax **Electronic Requests:** ☐ Patient Portal<br>**(Supply email address below ONLY if requesting records via Patient Portal)**<br>**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)