

**Authorization to Disclose Protected Health Information**

I hereby authorize \_\_\_\_\_ to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

**HAYDEL SPINE & PAIN SPECIALTY CARE CENTER.**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Disclose the following PHI for treatment dates \_\_\_\_\_ to \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abstract/Pertinent | <input type="checkbox"/> History & Physical       | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Consult            | <input type="checkbox"/> Operative Report         | <input type="checkbox"/> Progress Notes    |
| <input type="checkbox"/> Physical Orders    | <input type="checkbox"/> Nurses Notes             | <input type="checkbox"/> ER Report         |
| <input type="checkbox"/> Lab                | <input type="checkbox"/> X-ray / Radiology Report | <input type="checkbox"/> entire Chart      |
| <input type="checkbox"/> Radiology reports  | <input type="checkbox"/> Other: _____             |  |

Purpose for Release: **MEDICAL TREATMENT**

\_\_\_\_\_ I hereby acknowledge, and hereby consent to such, that the released information may  
 Initial contain alcohol and drug abuse, psychiatric, HIV, or genetic information.

This authorization shall expire upon this expiration date: \_\_\_\_\_.

If I fail to specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to **Haydel Spine & Pain Specialty Care Center**. I understand that the revocation will not apply to information that has already been released prior to this authorization. I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above. **PROHIBITION ON REDISCLOSURE:** This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**A photostatic copy of the form shall constitute my authorization to provide any information as described above.**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
 Signature of Patient (or Guardian or Legal Representative)  
 (if signed by someone other than the patient, state legal relationship/authority)