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| AUTHORIZATION FOR ACCESS/RELEASE/DISCLOSURE OF HEALTH INFORMATION |
|  |  |  |  |  |  |  |  |  |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Chart ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |
| Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| 1. TYPE OF ACCESS/RELEASE/DISCLOSURE: I hereby authorize **Edison Spine Center** to provide: |
|  |  |  | □ Access to review Health Information  | □ Photocopies of my Health Information, as requested below: |
|   |   |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |
| 2. DATES/DESCRIPTION OF INFORMATION TO BE RELEASED/DISCLOSED: *(Check ALL that apply)* |
| □ Office Notes |  | □  | Operative Reports |  | □Pathology Reports |
| □ History & Physical |  | □  | X-Rays Reports |  |  |  |
| □ Progress Notes |  | □  | EKG/EEG Reports | □ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_ |
| □ Consultation Reports | □  | Lab Reports | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Entire Medical Records |  | Date(s) of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |   |   |   |   |   |   |   |   |
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| 3. SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR THIS RELEASE/DISCLOSURE: |
| By signing my initials, I understand that the information to be released/disclosed from my medical record may include  |
| information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human |
| immunodeficiency virus (HIV), genetic information and tuberculosis information. It may also include information about |
| behavior or mental health services, and treatment for alcohol and drug abuse. |  |  |  |
|  |  |  |  |  |  | Patient Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |   |   |   |   |   |   |   |   |
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| 4. RELEASE/DISCLOSURE OF INFORMATION TO: | □Myself |  |  | □ To organiz./indiv. |
|  |  |  |  |  |  |  |  |  |
| Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Individual Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |
| Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Please mail |  | □ Please prepare for pick-up |
|   |   |   |   |   |   |   |   |   |
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| 5. PURPOSE OF RELEASE/DISCLOSURE: I authorize **Edison Spine Center** to  |  |
| release/disclose my health information for the following specific purpose(s): □ Medical Care □ Insurance  |
| □ Personal □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| 6. TERM/EXPIRATION: This signed authorization will expire in **6** months unless an earlier date is indicated by you |
| below. Please list a date or event when this authorization will no longer be valid *(this date may not be more than 6* |
| *months in accordance with Edison Spine Center’s policy).* This authorization will no longer be valid  |
| after: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |  |  |  |  |  |
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| 7. I understand that I have a right to revoke this authorization at any time. |  |  |  |
| ▪ I understand that if I revoke this authorization, I must do so in writing.  |  |  |  |
| ▪ I understand that revocation will not apply to information that has already been released/disclosed in response to this |
|  authorization. |  |  |  |  |  |  |  |
| ▪ I understand that the revocation will not apply to my insurance company when the law provides my insurer with the |
|  right to contest a claim under my policy. |  |  |  |  |  |
| ▪ I understand that authorizing the release/disclosure of this health information is voluntary. |  |  |
| ▪ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain |
|  treatment. |  |  |  |  |  |  |  |  |
|   |   |   |   |   |   |   |   |   |
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| 8. I understand that Edison Spine Center may deny this request under limited circumstances as |
| provided under Federal and State law protecting the privacy of health information. |  |  |
|   |   |   |   |   |   |   |   |   |
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| 9. I understand that the cost of copying medical records is $1.00 per page. I have to make payment in full  |
| before medical records are released. |  |  |  |  |  |
|   |   |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |
| 10. I hereby authorize the access/release/disclosure of my individually identifiable health information, as described  |
| above. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer |
| protected by Federal privacy regulations. However, the recipient may be prohibited from disclosing substance abuse |
| information under the Federal Substance Abuse Confidentiality Requirements. |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |
| If the patient is a minor or otherwise unable to sign this authorization then obtain the signature of the |
| authorized representative/individual below. |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Description of Authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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