AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Atlantic Spine Specialists, 131 Madison Avenue, Morristown, NJ 07960

Patient Name: _____
Previous Name (if applicable): _____
Date of Birth: _____

Name of Legal Representative (if applicable): _____
Relationship: _____

Patient Authorization

I hereby authorize you to use or disclose ONLY the following health care information (check all that apply):

☐ Release	☐ Do **NOT** Release	All my health information maintained by the above named practice
☐ Release	☐ Do **NOT** Release	My health information related to drug abuse
☐ Release	☐ Do **NOT** Release	My health information related to alcohol abuse
☐ Release	☐ Do **NOT** Release	My health information related to HIV/AIDS
☐ Release	☐ Do **NOT** Release	My health information related to psychological or psychiatric conditions *EXCEPT Psychotherapy Notes, as is defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501.* ***Psychotherapy notes require a separate authorization.***
☐ Release	☐ Do **NOT** Release	My health information relating to the following treatment or condition
☐ Release	☐ Do **NOT** Release	My health information for the date(s):
☐ Release	☐ Do **NOT** Release	Other: Xrays, MRI's, CT's, Discograms

The designated health information noted above may be disclosed to:

Name (or title) and organization: _____
Address: _____
City: _____ State: _____ Zip: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This information and authorization may be disclosed and/or used ONLY for the following reason(s):

_____

_____

This authorization expires: ☐ Date: _____ (If a date is not specified, this authorization will expire 6 months from the date signed)

☐ When the following event occurs: _____

A **photocopy** of this authorization shall be considered as effective and valid as the original.

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

Right to Revoke Authorization

I understand that I may revoke this authorization in writing at any time. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The revocation letter must be signed by me or on my behalf by my legally authorized representative.

Once this office discloses the above designated health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I have requested a copy of this authorization: Yes ☐ No ☐

I have received a copy of this authorization: Yes ☐ No ☐

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.