AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and or organization(s) to disclose my protected health information

Organization: **AllSpine Laser and Surgery Center**

(P) 770-997-0600 (F) 678-565-3625

Address: **900 Eagles Landing Pkway, Stockbridge, GA 30281**

2. I authorize the following person(s) and/or organization(s) to receive my protected health information

Name(s): _____

Organization(s): _____

Address: _____

3. Specific description of the protected health information that I authorize for disclosure (please circle):

☐ Treatment notes ☐ Diagnostic test results ☐ History/physical note ☐ Narrative reports

☐ Billing data

4. Specific description of the purpose for each use or disclosure (please circle):

☐ Workers' Compensation Benefits ☐ Transfer of Records ☐ Other

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. I understand the information released may include information that may indicate the presence of communicable or veneral diseases which may includde, but are not limited to, diseases such as hepatitis,syphilis, gonorrhea, and the Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS).

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Patient's Signature: _____ Date: _____

Name: _____

Telephone: _____

Address: _____