

The Spine Institute

Patient Authorization for Use and Disclosure of Protected Health Information for Purpose Requested by the Practice

By signing this authorization, I authorize The Spine Institute to use and/or disclose certain protected health information (PHI) about me to _____

Name and Address of entity to receive this information

This authorization permits The Spine Institute to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.):_____

The information will be used or disclosed for the following purpose:

The Practice will receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. }

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____

[Expiration Date or Defined Event]

Duration of treatment

I do not have to sign this authorization in order to receive treatment from The Spine Institute. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 2811 Wilshire Blvd., Suite 850, Santa Monica, CA 90403

Signed by: _____
Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian