

**AUTHORIZATION TO RELEASE PROTECTED
HEALTH INFORMATION**

<p>Atlantic Spine Specialists 131 Madison Avenue, Suite 110 Morristown, NJ 07960</p>

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):

<input type="checkbox"/> Release	<input type="checkbox"/> Do NOT Release	All my health information maintained by the above named practice
<input type="checkbox"/> Release	<input type="checkbox"/> Do NOT Release	My health information related to drug abuse
<input type="checkbox"/> Release	<input type="checkbox"/> Do NOT Release	My health information related to alcohol abuse
<input type="checkbox"/> Release	<input type="checkbox"/> Do NOT Release	My health information related to HIV/AIDS
<input type="checkbox"/> Release	<input type="checkbox"/> Do NOT Release	My health information related to psychological or psychiatric conditions <i>EXCEPT Psychotherapy Notes, as is defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501. Psychotherapy notes require a separate authorization.</i>
<input type="checkbox"/> Release	<input type="checkbox"/> Do NOT Release	My health information relating to the following treatment or condition
<input type="checkbox"/> Release	<input type="checkbox"/> Do NOT Release	My health information for the date(s):
<input type="checkbox"/> Release	<input type="checkbox"/> 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: _____

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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
personal representative, etc.)

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.