AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AND DISCLOSURES

Name of Individual:_____Other Alias_____

Date of Birth:_____

Address:_____

Phone:_____Email:_____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization: _____

Address:_____

Phone: _____ FAX:_____

Please release the following:

☐Treatment notes ☐Radiology Records ☐Procedure/Operative Notes ☐Lab Results

Other_____

WHO CAN RECEIVE AND USE THIS HEALTH INFORMATION?

Person/Organization: miSPINE & Joint Care, PLLC_____

Address: 1970 W University Dr, Ste 210, Prosper, TX 75078_____

Phone: 469-757-7623_____FAX: 469-757-7613_____

Reason for disclosure

☐Treatment/continuity of care	☐Personal Use	☐Billing or Claim
☐Disability Determination	☐Insurance	☐Legal Purposes
☐School	☐Employment	☐Other

EFFECTIVE TIME PERIOD. This authorization is valid for 365 days; or until the permission is withdrawn; or until the following specified date:_____

** By signing I understand that the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health records may include information relating to AIDS, HIV, and/or sexually transmitted disease.*

_____

PATIENT SIGNATURE/AUTHORIZED REPRESENTATIVE DATE:_____