HIPAA Privacy Authorization Form: Who do you want your medical records to go to?

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization: I authorize ***All Spine Care, LLC*** to disclose my protected health information to _____(individual seeking the information).
2. Effective Period: This authorization for release of information covers the period of healthcare from:_____to_____OR___all past, present, and future periods.
3. Extent of Authorization: I authorize the release of my complete health record (including images and labs).
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until_____(date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

You have a right to receive a copy of this notice at any time upon request.

Signature of patient or personal representative:

_____

Printed name of patient or personal representative and his or her relationship to patient:

_____

Date:_____/_____/ _____