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SPINAL SURGERY
CRANIAL SURGERY
MICRONEUROSURGERY
SPINAL INSTRUMENTATION

Authorization for Release of Information

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name: ____ **Date of Birth:** _________________________________

Persons/organizations providing the information:

____
____
____
____

Person/organizations receiving the information:

____
____
____
____

Specific description of information (including date(s)): ____
____
____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure? ____
   ____
   ____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes** ____ **No** _____

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials:** ________
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** __________

Section C: Must be completed for all authorizations
The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ **Initials: _________**
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. **Initials: ________**

____ ______________________________
Signature of patient or patient's representative **Date**

Printed name of patient's representative: ________________________________

Relationship to the patient: ____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

____ ____
Signature of Person Picking up Record & Date **or** **Signature of Employee Mailing Record & Date**

____ ____
Printed Name of Person Picking up Record **or** **Printed Name of Person Mailing Record**