AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Read entire document before signing: This authorization gives permission to use or disclose health information related to the patient listed below.

Patient Name: _____

Account Number: _____ Date of Birth: ____/____/_____

1. Center for Interventional Pain & Spine is authorized to disclose the health information of the above named individual as described in this authorization:
2. The Center for Interventional Pain & Spine may discuss and/or release protected health information with the following individuals (User/Recipient):
   Name _____Phone:_____
   Name _____Phone:_____
   May we leave telephone messages at the telephone number provided? ____yes ____no
3. The following health information can be discussed and/or released by this authorization to the individuals listed above:
   ❒Complete medical record
   ❒Appointment information including reason for appointment and times
   ❒Results of diagnostic testing and other information related to your health
   ❒Exceptions (Please List): _____

   Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

4. The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released

				Initials
Substance abuse records(drug or alcohol)	Yes ❑	No ❑	NA❑	_____
Mental health records protected by the Mental Health Procedures Act	Yes ❑	No ❑	NA❑	_____
HIV/AIDS related information	Yes ❑	No ❑	NA❑	____
Reproductive Health Information	Yes ❑	No ❑	NA❑	____

5. Please specify any other restrictions on the covered information: _____

I am requesting use or disclosure of the covered health information for the following purpose:

❒My personal use ❒Further medical treatment
❒ Insurance eligibility or benefits ❒School
❒Legal investigation or action ❒Other (please describe) _____

7. I understand that I have the following rights:

- **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by the Center for Interventional Pain & Spine except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
- **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:
  Center for Interventional Pain & Spine
  Attention: Jennifer Colonna SA-C, CHCO /Privacy/Security Officer
  291 Carter Dr. Middletown, DE 19709
- **Re-disclosure.** I understand that once the covered health information has been disclosed, it may be no longer protected by privacy laws and may be re-disclosed by the recipient.

8. **Expiration.** This authorization expires as of the following date or event_____

I have read and understand this authorization, and authorize the use or disclosure of the covered health information as described in this authorization.

_____ _____
Signature of patient (or personal representative/surrogate) Date

Personal Representative/Surrogate Information (as applicable):

_____ ____ _____
Name of personal representative Relationship to patiet