

Center for Interventional Pain & Spine
AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

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 use disorder (SUD) treatment records (42 CFR Part 2, if applicable)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	NA <input type="checkbox"/>	_____
Mental health records protected by the Mental Health Procedures Act	Yes <input type="checkbox"/>	No <input type="checkbox"/>	NA <input type="checkbox"/>	_____
HIV/AIDS related information	Yes <input type="checkbox"/>	No <input type="checkbox"/>	NA <input type="checkbox"/>	_____

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

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

<input type="checkbox"/> My personal use	<input type="checkbox"/> Further medical treatment
<input type="checkbox"/> Insurance eligibility or benefits	<input type="checkbox"/> School
<input type="checkbox"/> Legal investigation or action	<input type="checkbox"/> 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
Phone: 844-365-7246
Email: jennac@centerisp.com
- **Re-disclosure.** I understand that once the covered health information has been disclosed, it may no longer be protected by privacy laws and may be re-disclosed by the recipient. If the information disclosed includes substance use disorder (SUD) treatment records protected by 42 CFR Part 2, federal law generally prohibits the recipient from re-disclosing that information unless further disclosure is expressly permitted by the patient's written consent or as otherwise permitted by 42 CFR Part 2.

NOTICE TO RECIPIENT (only applies if you receive 42 CFR Part 2-protected SUD records): This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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 patient