Authorization for Use or Disclosure of Health Information

Processing Fee $25

$1 per page exceeding 25 pages

If records are mailed out: $5.00 (mailing charge)

The completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. Your request will be processed and fulfilled within 4-7 business days from the day it is received.

Patient Name:_____ **Date of Birth:**_____

Address: _____ **Telephone:**_____

Street

_____

City State Zip

I,_____, hereby authorize the Center for Spinal Restoration Clinic to use and/or disclosure of my health information as follows:

Person/Organizations authorized to use and/or disclose the information: _____

Person/Organizations authorized to receive the information: _____

Address of person/organization to receive the information:_____

Street City State Zip

This authorization applies to the following information:

_____ Entire record

_____ These specific dates only

Dates:_____

Purpose of use or disclosure of information:

_____ Required for insurance claim _____ Follow-up care _____ Personal use

_____ Comply with court order _____ Payment of bill _____ Application for insurance

_____ Update medical records other:_____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization

will expire on: _____.

Expiration Date/ or Event

Patient Rights:

1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to The Spine Institute, Center for Spinal Restoration 2811 Wilshire Blvd., Suite 850, Santa Monica, CA 90403.
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. I have a right to receive a copy of this authorization
6. Information disclosed pursuant to this authorization could be re-disclosed by the receipt and may no longer be protected by federal confidentiality law (HIPPA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I fully understand and accept the terms of this authorization.

Signature:_____ Date:_____

Patient/ representative /spouse/ financial responsible party

If signed by someone other than the patient state your legal relationship:_____

FOR OFFICE USE ONLY

☐Authorization added to the patient's record on _____.

☐Authorization verified by _____ on_____.

☐Patient has been provided with a copy of the signed authorization.