Interventional Spine & Sports Medicine, PC

Authorization for Release of Protected Health Information

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

Phone Number: _____ **SSN:** _____

Address: _____

I authorize the use or disclosure of my Protected Health Information (PHI) by Interventional Spine & Sports Medicine, PC (ISSM) as specified below. I understand that signing this authorization is voluntary and that ISSM may not require me to sign this authorization before ISSMprovides me with treatment. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice to ISSM. I understand that a description of my right to revoke my authorization is set forth in ISSM's Notice of Privacy Practices.

I understand that the information released pursuant to this authorization may no longer be protected by law or regulation and may be redisclosed by the recipient.

1) a) ISSM may use or disclose the following health information:
_____ The entire medical record (all information maintained by ISSM for the time period indicated below); or
_____ The following limited health information, (office notes, x-rays, operative reports, etc.)
_____
_____

b) ISSM cannot use or disclose certain information unless you specifically authorize such use or disclosure. Please initial next to each item below if you specifically authorize the release of health information relating to the testing diagnosis or treatment for:
_____ HIV/AIDS
_____ Drug and alcohol abuse
_____ Mental health/psychiatric disorders

2) Please specify the individual(s) or entity/entities that may use or receive the information requested by this authorization:

_____
_____
_____

3) Please specify the period during which you wish the information described above to be disclosed:

_____All information maintained at any time by ISSM, or
_____From ___/___/___ To ___/___/___

4) Unless earlier revoked, this authorization will expire on the following date: ___/___/___.

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- I am authorizing ISSM to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization: and
- If I have any questions about disclosure of my PHI regarding this authorization, I may contact the Privacy Officer at ISSM (203) 598-7246

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative Date

If signed by the individual's personal representative, describe the legal authority of the representative to act on behalf of the individual: _____

- Legal authority of representative verified by: _____