CAHABA PAIN AND SPINE CARE

RECORDS → SEND TO CAHABA PAIN AND SPINE CARE

Authorization to Disclose Health Information

Patient Name:_____ Date of birth : _____ / _____ / _____

1. I authorize _____ to disclose
(*Physician and/or Practice name you are coming FROM*)
the above named individual's health information as described below.

2. This information may be disclosed to and used by the following individual or organization:

Name: Cahaba Pain and Spine Care, LLC

Address: 2010 Patton Chapel Road, Suite 200 Birmingham, AL 35216

Office phone: (205)-208-9001 Office fax: (205)-208-0031

For the purpose: Medical evaluation and/or treatment

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ Office Visit Notes_____
- ❑ Patient Account Statement/Billing Records
- ❑ Medication list
- ❑ Procedure Notes_____
- ❑ List of allergies
- ❑ Most recent history and physical
- ❑ Most recent discharge summary
- ❑ Laboratory results From (date) _____ to (date) _____
- ❑ X-ray and imaging reports From (date) _____ to (date) _____
- ❑ Consultation reports From (doctors' names) _____
- ❑ Entire record

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to our Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: . _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact the Privacy/Security Officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to patient Signature of Witness