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HIPAA Authorization to Use and Disclose Protected Health Information (PHI)

INTRODUCTION

I have had the opportunity to read Spine & Pain Associates, PLLC's HIPAA Notice of Privacy Practices regarding the use and disclosure of protected health information (PHI). I understand that the practice does not need written patient authorization to securely release information related to Treatment, Payment and Operations (TPO). For example, I do not need to provide written permission to release information to a referring physician, insurance carrier or software vendor that is responsible for claims processing.

I also understand that I have choices regarding the authorization of Spine & Pain Associates, PLLC to release private information to designated individuals when necessary, as in the case of an emergency. For example, I may give the practice permission to release specific information to family members or friends. Details are listed below.

- Should I authorize such release of information, I may specify both the names of the individuals and the information that can/cannot be released.
- My signature is required in order to complete the request.
- Spine & Pain Associates, PLLC may use and disclose my PHI only until the expiration date or event relating to me for the specific purpose of the use or disclosure. This authorization is not a blanket permission to use and disclose PHI for an unlimited time period.
- I understand that PHI used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information. At that point, the PHI may no longer be protected under federal or state confidentiality rules.
- At all times, I retain the right to revoke this authorization to use and disclose PHI. Should I wish to exercise this right, I will submit a written request to the Spine & Pain Associates, PLLC Practice Administrator.
- I understand that Spine & Pain Associates, PLLC may charge a fee for copying the medical records for which I have provided authorization for use and disclosure.

If I choose not to authorize Spine & Pain Associates, PLLC to release my PHI to specific individuals and/or I choose not to sign this form, my decision will in no way affect my treatment, payment, enrollment in a health plan or eligibility for benefits.

PATIENT SIGNED AUTHORIZATION TO USE AND DISCLOSE PHI (PROTECTED HEALTH INFORMATION) TO SPECIFIC INDIVIDUALS

I have read and understand the information regarding the use and disclosure of PHI that is provided in the introduction above. I have received a copy of this form and I am the patient or individual authorized to act on behalf of the patient.

Medical Record Number: (to be filled in by practice)_____

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: Home: _____ Cell: _____ Work: _____

continued

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PATIENT AUTHORIZATION TO RELEASE INFORMATION

I, (Name)_____, hereby authorize Spine & Pain Associates, PLLC to release the following information:

- ☐ Consult Notes
- ☐ Office Visits
- ☐ Procedure Notes
- ☐ Pathology/Lab Reports
- ☐ Radiology Reports

to the following individuals:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

PATIENT RESTRICTION ON RELEASE OF INFORMATION

I, (Name)_____, do ____ do not ____ authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Patient Name or Name of Individual Authorized to Act on Patient's Behalf:

_____

Printed Name: _____

Signature: _____ Date: _____