SURGICAL SPINE ASSOCIATES

www.surgical-spine-associates.com
Phone: 412-275-0227 Fax: 412-291-2111

Authorization for USE or DISCLOSURE of Protected Health Information

I hereby authorize: _____ to release information

(Name of facility, entity, or practitioner)

From the record of: _____
Date of Birth: _____
SSN: _____

Release/disclose information to:
Surgical Spine Associates
1 Aesthetic Way
Greensburg, PA 15601

For the specific purpose of:

— Continued Care
__ Legal
__ Personal
__ Insurance
__ Other_____

Dates of treatment (approximate, if known): _____

____ Discharge Summary	____ PT, OT, SLP Evaluation	____ Radiology Reports
____ History/Physical Exam	____ Progress Notes	____ Photos, videos, images and films
____ Consults	____ Lab Tests/Exams	____ Psych Diagnostic Interview
____ Operative Report	____ Complete Health Record	Other _____

NOTE: Psychotherapy notes are excluded from this authorization, as they require a special authorization for use/ disclosure. Behavioral Health, AIDS or HIV, and Drug and Alcohol related information may be documented within the record indicated above and will be released through this authorization unless otherwise indicated.

Name: _____ **Date:** _____

PLEASE BE CERTAIN TO PROVIDE ALL APPROPRIATE SIGNATURES ON PAGE TWO OF THIS FORM. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING INFORMATION THAT RELATES TO YOUR SIGNING THIS AUTHORIZATION TO USE/DISCLOSE. PLEASE INITIAL WHERE INDICATED.

I **understand** that my authorization is necessary to **obtain or release** my health information and that I may revoke this authorization at any time, **in writing**, except to the extent that Surgical Spine Associates may have already relied upon it in making a use or disclosure. My written revocation will become effective upon Surgical Spine Associates having knowledge of it. If I have provided this authorization to obtain insurance coverage, I may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under my insurance policy. I understand that to revoke this authorization, I must send my written request to Surgical Spine Associates.

This authorization is **limited** to the **purpose**, to the person listed above, and will be in effect for **6 months** after the date of my signature, unless otherwise specified.

_____ This authorization will expire on the following date: _____

_____ Or when the following event occurs _____

I understand that information released by Surgical Spine Associates under this authorization may be re-disclosed by the receiving party, and therefore Surgical Spine Associates and its employees have no responsibility or liability as a result of any redisclosure; as such, the released information is no longer protected by the Privacy Rule.

I understand that Surgical Spine Associates cannot make me sign this authorization as a condition to receive treatment. **I understand** that I am entitled to a completed copy of the Authorization for Use/Disclosure form.

X_____ **X**_____

Date of Patient Signature | Patient Signature

(My signature confirms my understanding of the intended use of this authorization)

_____ _____

Date of Witness Signature | Witness Signature

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