SOUTHWEST NEUROSURGICAL ASSOCIATES

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____
Phone Home # _____ Work # _____ SS #_____

1. I authorize the use or disclosure of the above named individual's health information as described below. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

2. **Request Records From:** (Individual or organization authorized to make the disclosure)
_____

3. **Release Records To:** (Information listed in #4 below may be disclosed to the following individual or organization)

Name_____Phone#_____

Address _____ City_____ State_____ Zip_____

4. Specific description of information to be used or disclosed: _____ Entire Record

Specify: _____ from (date) _____ to (date) _____

Specify _____ from (date)) _____ to (date) _____

5. The information that will be disclosed will be used for the following purposes:
_____

6. I hereby expressly waive any laws, regulations or rules of ethics that might prevent any hospital, doctor, psychotherapist, laboratory or other health care provider who has examined or treated the above patient in a professional capacity or otherwise, from releasing such documents. Initials of patient _____

7. I understand I have the right to revoke this authorization at any time by notifying the individual or organization that is authorized to make the disclosure, in writing, except to the extent that action has been taken in reliance on this authorization; or if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest the claim or the policy itself. 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.

8. 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 I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that I have a right to receive a notice of privacy from any health care provider that discloses the above protected health information.

_____ _____
Signature of Patient (or Patient's Representative) Date

_____
Relationship to Patient (if signed by Patient's Representative)

Form Revised 8/4/10