PRECISION SPINE CARE

Authorization to Use or Disclose PHI

Patient Information (Please Print)			
First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

I am requesting my records from:

Facility Name: **Address:** **City/State Zip:**	**Facility E-mail:** **Facility Fax:**

What records do you want to receive or have disclosed to the recipient noted? (Check appropriate boxes below):

Date(s) of Service:____/____/_____through____/____/_____ ☐ ALL Dates of Services

☐ Progress Notes ☐ Discharge Summary ☐ History and Physical Consultation(s)
☐ Lab Reports ☐ Pathology Report ☐ Operative Note(s)

☐ Imaging/X-Ray Films ☐ Imaging/X-Ray Reports ☐ Entire Record

Other (specify)_____

If it exists, the following Sensitive Information can be disclosed:

☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

Recipient Name: **Precision Spine Care**	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**

Patient's Signature or Legal Representative		Date/Time
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if utilized	Date/Time

This Healthcare Facility recognizes a patient's right under HIPAA to access copies of his/her health information. There may becharges associated with processing a request and producing requested records.