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Authorization for Disclosure of Protected Health Information (Medical Records Request)

By signing this authorization, I authorize:

Entity Name _____
Contact Person _____
Address _____
Phone Number _____
Fax Number _____

to disclose certain protected health information (PHI) to **Athens Spine Center** as listed below.

What PHI may be used or disclosed:

This Authorization permits the Entity listed above to disclose the following PHI:

[Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.]

Describe the specific purpose(s) for which you authorize the Practice use or disclose this PHI:

At the request of the individual

To whom may the PHI be disclosed:

Athens Spine Center PC
855 King Avenue
Athens, GA 30606
706-425-2400 (Phone)
706-425-2410 (Fax)

This authorization will expire on six months from date signed below _____.

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (i) to the extent that the Entity has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Entity listed above stating that I wish to revoke this Authorization.

Signed by: _____
Signature of Patient or Personal Representative *Date Signed*

Print Name of Patient or Personal Representative: _____
[If signed by a Personal Representative, please state such person's authority to act for the Individual]

Date Signed