

* Patient Name: _____ SIA Physician: _____
 * Address: _____ * Date of Birth: _____
 * Social Security # _____ * Telephone: (Day) _____
 (Home) _____

THIS AUTHORIZATION EXPIRES: ON (DATE) * _____

*Per HIPAA Regulation an authorization for disclosure of Protected Health Information **MUST** have an expiration date. Your expiration date may not exceed six years from the initial date of authorization.*

*** I. My Authorization** - You may use or disclose the following health care information (check all that apply):

- All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care / Psychotherapy Notes, Alcohol and/or Drug Abuse Treatment
- All radiologic studies in Spine Institute of Arizona's possession. *(I understand and agree that I am financially responsible for the following fees associated with my request: I understand that there is a copying charge of \$7.00 per x-ray for my Spine Institute of Arizona x-rays films.)*
- All of my health information except the following: _____

*** II. Disclosure of My Health Information**

- Copies of my health information Inspection *(I agree not to make any marks on or alter the record in any way and understand an office representative will be present.)*

* TO: Name and / or Organization: _____
 - Address: _____
 - City: _____ State: _____ Zip Code: _____
 - Phone: _____ Fax: _____

* You may disclose this health information by: Mail Fax Patient Pickup

Spine Institute of Arizona may receive my health information by mail or fax from:

Physician/Facility: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____

*** Reason(s) for this authorization (check all that apply):**

- at my request _____ check here only when (physician or clinic) requests the authorization for marketing purposes
- other (specify) _____ check here only when (physician or clinic will get something of value for providing health information for marketing purposes

III. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a dated letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect it.

I understand that is this office has requested this authorization, I have a right to inspect or copy the information to be used or disclosed.

* Patient or legally authorized individual signature _____ Date _____

Printed Name if signed on behalf of patient _____ Relationship (parent, legal guardian, personal representative, etc.) _____

To Karen	Completed