



**SPINE
INSTITUTE
OF ARIZONA**

**Authorization for Disclosure of My Health Information to
My Spouse / Significant Other / Parent / Family Member**

9735 North 90th Place
Scottsdale, Arizona 85258
TEL 602/953.9500
FAX 602/953.1782

I, _____, hereby authorize that my Spouse / Significant Other / Parent / Family Member(s) may obtain or receive copies of my Protected Health Information to include, but is not limited to; office notes, prescriptions, imaging films.

Unless I revoke this authorization earlier, this authorization will expire six years from the date signed.

Name(s) of Spouse/Significant Other/Parent/Family Member(s)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE NOTE: *Your Spouse/Significant Other/Parent/Family Member(s) will be required to show legal I.D. prior to being able to obtain your Protected Health Information.*

Signature of Patient or Legal Guardian

Date

Patient or Legal Guardian's Printed Name