**Advanced Spine Associates, P.A.**

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Phone: 763.577.1877 • Fax: 763.577.1887 • Federal Tax ID #41-1897350

*Surgeons Specializing in Spinal Disorders*

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name_____ Birthdate: _____/_____/_____

Previous Names_____ Social Security # _____-_____-_____ (optional)

Phone Numbers (Home) _____ (Work) _____ (Other) _____

Release Records **FROM:**
**Clinic/Organization Name:** _____

Address: _____

City: _____State: Zip Code:_____ _____

Phone: _____ Fax_____

Please Release Records **TO:**
**Person/Clinic/Organization Name:** _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Fax: _____

Information to be Released/Reviewed:

_____

_____

_____

**For the following date(s) of treatment:** _____

The protected health information will be used and/or disclosed for the following purposes:

_____Insurance ____Medical ____Legal ____Other _____

- I hereby authorize Advanced Spine Associates, P.A. to release any of my pertinent information as deemed necessary under the HIPPA guidelines.
- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understate that I may revoke this authorization at any time by notifying Advanced Spine Associates P.A. in writing. However, if I choose to do so, I understand that my revocation will not affect any action taken by Advanced Spine Associates, P.A. before receiving my revocation.

This authorization expires on the following date: _____
(One year from date if not indicated above)

| _____ | _____ | _____ |
|---|---|---|
| **Signature of patient or authorized person** (If authorized person is signing please also print name) | **Authorized person's authority to sign** (Parent, guardian, power of attorney, etc.) | **Date** |

Reason patient is unable to sign ____Minor ____Deceased ____Other: _____