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Authorization for Use and Disclosure of Protected Health Information

Use this form to authorize Jax Spine & Pain Centers to disclose protected health information to yourself, an individual other than yourself, or to allow us to collect and/or send protected health information from/to another entity on your behalf.

Authorization — I authorize the use and disclosure of my protected health information as described below. I understand that my treatment, payment, enrollment or eligibility for benefits does **not** depend on whether I sign this authorization.

Patient Name:		Date of Birth:	
Address:			
City:		State & Zip:	
SSN#:		Phone:	

☐	Copies of the Medical Record	☐	Inspection of Record

***I authorize* the disclosure of**: *(Check all that apply.)*

☐	History & Physical	☐	OP Reports
☐	Lab/Pathology Reports	☐	Anesthesiology
☐	Face Sheet	☐	Imaging/Radiology
☐	Nursing Notes	☐	Physician Progress Notes
☐	Physician Orders	☐	Entire Record

I authorize release of information to: *(Check all that apply.)*

☐ Jax Spine & Pain Centers	☐ Self	☐ Other	
Name:		Phone/Fax:	
Address:			
City:		State & Zip:	

Method of Release - ☐ Fax: (____)________________ ☐ Email: ____________________ ☐ Mail

I further authorize the disclosure of: *(Check all that apply.)*

☐	Mental Health Conditions or Treatments	☐	Substance Abuse
☐	Genetic Disorders	☐	HIV/AIDS
☐	Other Sexually Transmissible Diseases	☐	Other: *(Please specify.)*

The purpose of the use or disclosure is:

I understand that once information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations. I hereby release (the facility) and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records supervisor. I understand the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire in **one (1) year** from the date signed below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. If I have questions about disclosure of my health information I can contact Medical Records, Patient Services or the Privacy Officer.

Signature of Patient or Legal Representative	Relationship to Patient	Date