Authorization For Use or Disclosure of Medical Record Information

Medical Record #

SPINE INSTITUTE

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize CCSI to release my medical records to the following:

☐ Mail Copies To *(address below)* ☐ Hold for Patient Pick-up ☐ Discuss Medical Record Information With *(address below)*

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ○ * Personal ○ Continuing Care ○ * Legal ○ * Insurance ○ * Other _____

**COPY FEE : We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Base fee: $14.00 pages 1-10, $.50 pages 11-39, and $.33 thereafter. Please make checks payable to Bactes.*

Information to be Released

PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.

_____ Date(s) of Treatment _____

_____ Date(s) of Treatment _____

OK To Release Self Paid Procedure Notes? YES ___ NO___ Date(s) of Treatment _____

Authorization for Release of Statutorily Protected Information

DO NOT Leave This Section Blank - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for CCSI to properly process your medical record request.

Release Records? Check one

	Yes	or	No	
Mental Health	☐		☐	Initial Here: _____
HIV Tests & Related Information	☐		☐	Initial Here: _____
Alcohol and/or Substance Abuse	☐		☐	Initial Here: _____

STOP Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, CCSI may be unable to fulfill this request.

Sensitive Information

Please check or indicate below any sensitive information that you **DO NOT** want released.

☐ Abortion ☐ Sexually Transmitted Disease ☐ AIDS/ARC

☐ Genetic ☐ Domestic Sexual Assault ☐ Drug and Alcohol

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature/Relationship To Patient** **Date***

Witness **Date**

Know Your Privacy Right refer to the HIPAA "PRIVACY NOTICE"

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify other wise:_____. You may revoke this Authorization at any time by providing a written statement to the CCSI clinic where the Authorization was originally submitted, except to the extent that NWP has already completed action on it.

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following:_____

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. CCSI will not condition treatment or payment of the provision of this Authorization. Patient does have a right to receive a copy of this form