Premier Spine & Pain Center

Authorization for Release of Protected Health Information

Patient Name:	Date of Birth :	Social Security No:
Provider (Who is releasing information):		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax Number:	

I hereby authorize my protected health information from the above provider to be released to:

Recipient's Name (Who is receiving the information):		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax Number:	

This authorization will expire upon the following: (Fill in the Date or Event, but not both.)

(If no expiration is specified, this authorization will expire 90 days from the date signed.)

*The following information may be disclosed (Choose one of the following):

_____ All Medical Records covering dates_____through _____

_____ Entire Medical Record

_____ Specific Medical Records _____

_____ Other (Specify): _____

***I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information._____(Initial) If not applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see & obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it.
6. I may retain a copy of this form after I sign it.

Signature of Patient / Guardian / Legal Representative:	Date:
(If not signed by the Patient) Print Name:	Relationship to Patient:

Legal Paperwork is required if not signed by the patient.