The Spine Institute

Fax Number: 801-314-2345

Authorization to Use and Disclose Protected Health Information

Authorization to release the health information of:			
Patient Name:	MRN		
Current Address:	City:	State:	Zip:
Phone:	Date of Birth: / / (mm/dd/yyyy)		
This Authorization is to release health information to:			
Name:		Fax:	
Address:	City:	State:	Zip:
The purpose of this disclosure is: • Patient Request • Treatment • Payment purposes • Other Specify:			
Dates of Service:			

Release the following information and procedure notes:

- ☐ Initial Visit
- ☐ Treatment Plan(s)
- ☐ Lab report(s)
- ☐ All
- ☐ Psychology record(s)
- ☐ Radiology report(s)
- ☐ Progress Notes
- ☐ Other records as Specified: _____
- ☐ Pathology report(s)
- ☐ Operative Report(s)
- ☐ X-ray films / CD

Term: This Authorization will remain in effect :

• From the date of this Authorization until: _____

• Until the following event occurs: _____

Unless otherwise noted above this Authorization will remain in effect 180 days from the date signed.

I understand that:

- Once ISI discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a 3rd party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to ISI to inspect and/or obtain a copy of my health information maintained at this facility as provided by Federal Rule 45 CFR § 164.524.
- My records are protected and cannot be disclosed without my permission. *Alcohol/drug treatment records are protected by Federal Privacy Rule 42 CFR, part 2.
- This Authorization will remain in effect until the Authorization expires or I provide written notice of revocation to the Health Information Services / Medical Records Department.

To be used if facility requests this Authorization:

I understand that:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of ISI treatment of me, enrollment in the health plan, or eligibility benefits.
- I may make a request in writing at any time to ISI to inspect and/or obtain a copy of my health information maintained at this facility as provided by Federal Rule 45 CFR § 164.524.

If I have questions about disclosure of my health information, I can contact the ISI Medical Records Department.

Signature of patient or Legal Representative	Date:
If Signed by Legal Representative, Relationship to Patient:	Signature of Witness (optional)