Fax: (775) 622-4150 Email: Contact@ProCarePainandSpine.com

HIPAA Compliant Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City/State/Zip Code: _____

This Authorization allows ProCare Pain and Spine to:

☐ **Send** copies of your medical record to the provider/person/facility below.

☐ **Receive** copies of your medical record from the provider/person/facility below.

Name of Provider/Person/Facility: _____

Phone: _____ Fax:_____

Address: _____ City/State/Zip: _____

Purpose of Request: Healthcare Appointment and Coordination of Care

Information to be Released:

□ Initial Consultation Note □ Most Recent Office Visit Note(s) □ Radiology Reports: _____

□ Procedure Note(s) □ Dates of Service: From: _____ to _____ □ Other: _____

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans, or health care clearinghouses, which must follow federal standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights with Respect to this Authorization:
1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above-named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for the duration that I am an active patient. To initiate revocation of this authorization, I must submit this in writing to ProCare Pain and Spine. 3) I understand that a digital replication of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by federal law. 5) I understand that I have the right to refuse to sign this authorization, I am signing this authorization voluntarily, and that treatment, payment, or eligibility for benefits may not be conditioned on obtaining this authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of; Alcohol, Drug Abuse and/Psychiatric records, Sexually Transmitted Disease(s), and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to obtain copies of my health information, by contacting the Compliance/Privacy Officer.

Expiration Date: This authorization is valid while under active treatment, and will expire upon discharge from the practice, or the following date _____.

I have reviewed and understand the content of this authorization form. By signing this authorization, I am confirming it accurately reflects my permission.

Signature of Patient or Legal Representative: _____ **Date**: _____

Witness: _____ **Date** _____

If not signed by patient, select authorized authority (provide documentation):

□ Parent of Minor Child □ Power of Attorney □ Representative of Custodial Adult □ Other: _____