

# HIPAA Authorization for Release of Information To Family and/or Friends

Name of Patient \_\_\_\_\_ DOB \_\_\_\_\_

Neurospine Institute is authorized to release protected health information about the above named patient in the following manner:

\_\_\_\_\_ Leave information on voicemail at:

Home  Work  Cell Phone

\_\_\_\_\_ Give information to spouse.

\_\_\_\_\_ Give information to: \_\_\_\_\_.

## Description of information to be released:

\_\_\_\_\_ Appointment Reminders Cards \_\_\_\_\_ Medical Information

\_\_\_\_\_ Financial Information \_\_\_\_\_ Information results from tests or xrays.

\_\_\_\_\_ Other information as described: \_\_\_\_\_.

## Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Neurospine Institute.

I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Personal Representative

\_\_\_\_\_ Description of Personal Representative's Authority (attach necessary documentation)