INNOVATIVE PHYSIATRY SPINE CLINIC
PATIENT FIRST

165 Durbin Station Ct., Suite 601,
St. Johns, FL 32259
Phone: (904) 671-0288
Fax: (904) 508-0674

Authorization for Release of Medical Information from Medical Record

Patient's Name: _____
Last First M.I.

D.O.B.:_____ Social Security No.:_____

AUTHORIZATION: I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law.

RELEASE FROM LIABILITY: I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Innovative Physiatry Spine Clinic from any and all legal liability that may arise from the release of this information to the party named below.

ORGANIZATION PROVIDING / RECEIVING *(circle one)* INFORMATION:

_____
Name of Person or Organization Providing/Receiving Information

_____
Street Address, City, State, & Zip code

INFORMATION TO BE DISCLOSED:

☐ All records OR ☐ Demographic Information ☐ Lab Reports ☐ Diagnostic Test Reports
☐ X-Ray Films ☐ Consultant Reports ☐ Other (please specify):_____

Alcohol/Drug/Infectious Disease/Mental Health Records are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as checked below. I understand that the following records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

In addition to any records checked above, the following checked records may be released:

☐ HIV/AIDS related information and/or records ☐ Mental Health information and/or records
☐ Sexually transmitted diseases ☐ Drug/alcohol diagnosis, treatment or referral information

PURPOSE OF DISCLOSURE:

☐ Continuing Medical Treatment ☐ Second Opinion ☐ Patient Request
☐ Marketing Promotion: I have been informed Innovative Physiatry Spine Clinic __is __ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.
☐ Sale of PHI: I have been informed that Innovative Physiatry Spine Clinic __is __ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.
☐ Other: _____

I understand that this authorization will expire one (1) year from the date of my signature below. I also understand that I may revoke this authorization at any time, in writing to the practice, before the information has been released. I further understand that I have a right to receive a copy of this authorization upon request.

_____ _____
Patient Signature Date

_____ _____
Legal Representative Signature/Authority Witness Signature