

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Medical Record / Account Number (if known): _____

1. AUTHORIZATION

I hereby authorize **Spine by Villamil, MD** ("Covered Entity") to release/disclose the protected health information described below.

2. INFORMATION TO BE RELEASED

- ☐ Complete medical record
- ☐ Specific dates of service: From _____ to _____
- ☐ Office notes / progress notes ☐ Laboratory results ☐ Imaging / radiology reports
- ☐ Billing / payment records ☐ Mental health records* ☐ Substance use disorder records*
- ☐ Other (please specify): _____

* Special categories of records (e.g., psychotherapy notes, substance use disorder treatment records under 42 CFR Part 2) may require additional specific authorization and cannot be disclosed under a general authorization in many cases.

3. PERSON(S) / ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION

Name / Organization: _____

Address: _____

Phone / Fax / Email: _____

Relationship to Patient (if any): _____

4. PURPOSE OF THE DISCLOSURE

- ☐ At the request of the individual (patient) ☐ Continuity of care / treatment
- ☐ Legal / attorney request ☐ Insurance / billing
- ☐ Other (please specify): _____

5. EXPIRATION

This authorization expires on: _____ OR upon the following event: _____

(If left blank, this authorization will expire one year from the date of signature.)

6. REQUIRED STATEMENTS

- I understand that I have the right to revoke this authorization at any time by submitting a written revocation to the Covered Entity, except to the extent that action has already been taken in reliance on this authorization.
- I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization (except in limited circumstances permitted by law).
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- I understand that I may inspect or copy the information to be used or disclosed, as provided by law.

7. SIGNATURE

I have read and understand this authorization. I am the patient or the patient's authorized personal representative.

Patient / Personal Representative Signature: _____ Date: _____

Printed Name of Signer: _____

If signed by Personal Representative — Relationship to Patient / Authority to Act: _____

(Attach supporting documentation if required, e.g., power of attorney, guardianship papers)

FOR OFFICE USE ONLY

Date received: _____ Staff initials: _____ Method of release: ☐ Mail ☐ Fax ☐ Electronic ☐ Pick-up

Date released: _____ Notes: _____