Innovative Spine and Pain Institute
Where pain stops and life begins

7655 Five Mile Road, Suite 117
Cincinnati, OH 45239
Office: 513.624.7525
Fax: 513.624.0578

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____

Date of Birth: _____ Last 4 SSN:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____

I authorize the release of the following information:
□ All Records Available from (date) _____to (date) _____
□ Test/Laboratory Results Please Specify: _____
□ Medication List
□ Physician notes
□ Other – Please Specify: _____

The health information should be sent from:
Name: Brandon Harris, M.D.
Address: 7655 Five Mile Road Suite 117 Cincinnati, OH 45230

The health information should be sent to:
Please mark one: □ Physician or Medical Office □ Attorney □ Other_____
First Name: _____ Last Name: _____
Address: _____City, State & Zip_____
Phone Number: (___)_____ Fax Number: (___)_____

Reason Needed ***(Mark only one):***
□ Personal □ Treatment □ Legal
□ Disability through employer **Specify**: □ Long-term OR □ Short-term
□ Applying for Social Security Disability
□ Other: _____

THIS REQUEST WILL NOT BE PROCESSED UNLESS ALL INFORMATION IS PROVIDED!

This information to be released at my request.

I understand that I have the right to cancel this authorization at any time by presenting my written cancellation to the practice. I understand that a cancellation will not apply to information that has already been released under this authorization.

Expiration: This authorization will expire in one year or on the following earlier date: _____.

I understand that authorizing the disclosure of this PHI is strictly voluntary and I do not need to sign this form in order to obtain treatment. Treatment will not be withheld if I do not sign this authorization.

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I understand that the information to be released may include information concerning sexually transmitted disease (STD), Human Immunodeficiency Virus (HIV) testing, diagnosis, or treatment of Acquired Immunodeficiency Syndrome (AIDS), AIDS-related conditions, drug/alcohol abuse and/or drug related conditions, and psychiatric/psychological conditions.

Re-disclosure: I understand that any release of my health information to a person or entity not covered by the HIPAA Rules has the risk of re-disclosure and may no longer be protected by the Federal Law. If the information disclosed includes alcohol or drug treatment records, the person(s) receiving the records is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

I understand I will receive a copy of the signed Authorization Form to keep for my records.

_____ _____

Patient / Personal Representative **Date**

If signed by a personal representative, please complete the following:

Name/Personal Representative (please print): _____

Relationship to Patient: _____

Authority of Personal Representative – *e.g.*, health care power of attorney, guardian, other statutory authority

(Proof of identity required): _____

Address: _____

Phone Number: _____

Staff use only:

Payment: □Yes Amt: _____ □No □N/A **Staff Initials** _____