3161Howell Mill Road NW
Atlanta, Georgia 30327
(p) 404.351.5812 (f) 404.350.8166

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

The undersigned authorizes SpineCenterAtlanta & Affiliates to release my health information as noted below.

Patient Full Name: ______________________ Other Names? ______________________

Patient Address: ______________________ Date of Birth: ______________

City: ____________ State: ________ Zip: __________ Phone Number: _____ - _____ - ______

RELEASE INFORMATION TO:

Name/Facility: ______________________ Attention: ______________________

Address: ______________________ Phone Number: _____ - _____ - ______

City: ____________ State: ________ Zip: __________ Fax Number: _____ - _____ - _______

Email Address: ______________________

Purpose of Request: □ Personal □ Treatment □ Legal □ Insurance □ Transfer □ Other: ______________

INFORMATION TO BE RELEASED: *If you fail to specify, a 1 year abstract will be provided.*

□ Please release a **1 year abstract** of my records
(Includes most recent notes, labs, procedures & testing)

□ Please release a **2 year abstract** of my records
(Includes recent notes, labs, procedures & testing up to 2 years)

□ **Data Range**: ______________________
□ Progress notes □ Radiology reports □ Labs
□ Operative reports □ Injections □ Physical Therapy
□ Other: ______________________

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Georgia state law.

Records being sent to another healthcare provider or a 3rd party payer will be sent at **no** cost.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * ____________ *(Please Initial)*

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______________________. *If I do not specify expiration this authorization will expire in 365 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if asked for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety – if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*: ______________________ Date: _______ / _______ /_______

**For non-emancipated minors under the age of 18, a parent or guardian must sign this release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*