



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Use this form to request records from another provider or to authorize Hardy Pain and Spine Institute to release records.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: _____ Medical Record # (if known): _____
Address: _____
City: _____ State: _____ ZIP: _____

DIRECTION OF AUTHORIZATION

- ☐ I authorize the provider/organization below to RELEASE information TO Hardy Pain and Spine Institute.
☐ I authorize Hardy Pain and Spine Institute to RELEASE information TO the person/organization below.

Name of Provider / Organization / Individual: _____ Phone: _____
Fax: _____ Email (if applicable): _____
Address: _____

INFORMATION AUTHORIZED

- ☐ All medical records ☐ Office notes ☐ Consultations ☐ Procedure/operative reports ☐ Imaging reports ☐ Imaging images/films
☐ EMG/nerve conduction reports ☐ Laboratory results ☐ Medication/pharmacy records ☐ Billing/itemized statements ☐ Other

Other / specific information:

Dates of Service: ☐ All dates ☐ Specific dates from _____ to _____

Body area / condition (optional): _____

PURPOSE

- ☐ Continuity of care ☐ At my request ☐ Insurance/benefits ☐ Legal matter at my request ☐ Other

Other purpose: _____

SPECIALLY PROTECTED INFORMATION

Some categories of information may be subject to additional federal or state protections. If such information is included, an additional or more specific authorization may be required. I specifically authorize disclosure of the following when legally permitted:

Initial each category you authorize: _____ Mental health records _____ HIV/AIDS or other communicable-disease records _____ Substance-use-disorder treatment records _____ Other specially protected records: _____

EXPIRATION, REVOCATION & REDISCLOSURE

This authorization expires one year from the date signed unless I write a different expiration date or event here: _____. I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy rules. Signing is voluntary; treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing except where permitted by law. I understand I may request a copy of this signed authorization.

If signed by a legal representative, describe authority: _____

Representative relationship / supporting documentation (if applicable): _____

SIGNATURE

Patient/Legal Representative Signature

Date

Printed Name