Authorization for Use and Disclosure Of Protected Health Information

NOVASPINE PAIN INSTITUTE
Your Minimally Invasive Spine, Pain & Arthritis Care Experts ™

By signing below, I authorize NovaSpine Pain Institute, its agents and employees ("**Provider**"), to use and/or disclose any and all of my protected health information ("**Records")** on my behalf, of any kind and description, to the following ("**Recipient**"):

Recipient Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

I also authorize Provider to release my protected health information to my insurance, primary care provider(s), referring provider(s), hospitals, diagnostic centers and/or laboratories that may require this information for continued care and authorize Provider to transmit this information through electronic means.

Authorization to Disclose Protected Health Information including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnoses or treatment for HIV, HIV-related diseases and communicable disease-related information. With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

I understand I have the right to refuse to sign this authorization, writing, at any time and that I do not have to sign this authorization to receive treatment at Novaspine Pain Institute. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is:

NovaSpine Pain Institute, Attn Privacy Officer, 13203 N 103rd Ave Ste H4 Sun City West AZ 85351

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. 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.

This Authorization will remain effective until one-year following the date set forth below, or, if not date is set forth below, the date Novaspine Pain Institute receives this executed Authorization, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____