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Authorization to Discuss, Release and/or Obtain Medical Information

Patient Name: Date of Birth: Email:
Address: Preferred Phone:

I hereby authorize Atlas Neurosurgery and Spine Center to call and/or leave messages on my home phone, cell phone and/or email. I understand that each of these communications are NOT considered completely secure since someone else could access the information.

- I hereby authorize Atlas Neurosurgery and Spine Center to discuss my medical care with the following individuals (i.e. relatives/caregiver):

Name: Relationship:
Name: Relationship:

- I hereby authorize Atlas Neurosurgery and Spine Center to contact the following individual in case of an emergency:

Name: Relationship: Contact Number: () -

- I hereby authorize Atlas Neurosurgery and Spine Center to RELEASE copies of the following medical records:
all my medical records other records:

Release my medical records to this Individual/Institution/Physician:
Relationship: Phone: () - Fax: () -
Address: City: ST: ZIP:

- I hereby authorize Atlas Neurosurgery and Spine Center to OBTAIN copies of the following medical records:
all my medical records other records:

Obtain my medical records from this Individual/Institution/Physician:
Relationship: Phone: () - Fax: () -
Address: City: ST: ZIP:

I authorize Atlas Neurosurgery and Spine Center to send/receive confidential information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996) to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care and as authorized above. "The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning or authorizations in paragraph (b)(4) of [45 C.F.R. § 164.508] applies." 45 C.F.R. § 164.508(c)(2)(ii)(A). I understand a potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule. 45 C.F.R. § 164.508(c)(2)(iii). I may revoke this authorization in writing, except to the extent that we have already used/ disclosed your information. When your medical information is used/disclosed pursuant to this authorization it may be subject to re-disclosure by a person who received your information. This re-disclosure may not be protected by the applicable privacy laws. You have the right to submit a written request to inspect and copy your medical records. In certain limited circumstances this request may be denied. By signing below, I hereby release Atlas Neurosurgery and Spine Center from all legal responsibility/liability that may arise from the act I have authorized above.

Name of Patient/Legal Representative Signature Date