Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

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