Patient Name:

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand Premier Spine Institute Bonaventure Ngu, MD is authorized by me to use or disclose my protected health information ("PHI") for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

I specifically authorize Premier Spine Institute Bonaventure Ngu, MD or its designated employee(s) to disclose my PHI as described on this form to the recipients listed below. I understand that when the 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 state or federal privacy regulations. I further understand that I retain the right to revoke this authorization if I do so in accordance with the steps set forth below.

Description of the information to be used or disclosed *(check all that apply):*

☐ **My entire record**
Note: This requires an explanation of why it is necessary to disclose the entire record

____
____
____

☐ **My demographic information** *(check all that apply):*

☐ Name ☐ Address ☐ State/Zip Code only ☐ Telephone
☐ Age ☐ Gender ☐ Race ☐ Other___________

☐ **Medical Data/Information related to:**

☐ Specific condition(s) ______________________________
☐ Specific professional service(s)______________________________
☐ Specific medication(s)______________________________
☐ Other ______________________________

☐ **Other** ______________________________

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Patient Name:

Please disclose the above information to:

Name _______________________________________ Phone Number______________________

Address____

I ☐ do ☐ do not authorize this information to be faxed. If yes, fax number___________________
Name(s) or class of person(s) to whom Premier Spine Institute Bonaventure Ngu, MD may disclose my PHI
____

Purpose(s) for the disclosure of the information:
____

____

____

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. For the revocation of this authorization to be effective, Premier Spine Institute Bonaventure Ngu, MD must receive the revocation in writing and the revocation must include:

- My name and address
- The effective date of this authorization and the recipients of the PHI according to this authorization
- My desire to revoke this authorization
- The date of the revocation, and
- My signature.

Premier Spine Institute Bonaventure Ngu, MD will accept written revocations of this authorization via:

☐ Certified U.S. mail
☐ Facsimile at this number: _______________________________

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Patient Name:

All revocations must be sent to Premier Spine Institute Bonaventure Ngu, MD and are not effective until received in our offices.

This authorization shall expire one year from the signature date unless revised by patient prior to that date.

I fully understand and accept the terms of this authorization.

Patient Name ____

Patient Signature _____________________________________ Date _______________________

Name of Representative _______________________________

Relationship to Patient ________________________________

FOR OFFICE USE ONLY

- ☐ Authorization added to the patient's record on _____________________________________
- ☐ Authorization verified by ______________________________on _____________________
- ☐ Patient has been provided with a copy of the signed authorization.

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