Advanced Spine Care

& Pain Management of New York, P.C

DR.SHAILESH PATHARE

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION PURSUANT TO HIPPA

NAME: _____ Date of Birth: _____

Social Security Number: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

This office and its designated agents may share or disclose any part of your health record to other physicians or healthcare facilities that participate in your care. This may include any or all of the following: alcohol or drug abuse, mental health diagnoses and treatment, HIV (or AIDS) related information.

At times, it may become necessary to share portions of your medical records with other agencies that indirectly participate in your healthcare. Such an example would include billing, transcription, Insurance companies, law firms, medical testing centers, governmental agencies, etc. This information can include doctor's notes, blood or X-ray results, billing or insurance records, referrals, and information that we have received from other healthcare facilities.

By signing below, you or your authorized representative acknowledge that you have read this letter and agree. You have the right to restrict the release of any and all parts of your medical records to a particular healthcare or non-healthcare facility. If you choose to do so, please specify below. You have the right to change your preferences (i.e. revoke this authorization) at any time in the future.

Advanced Spine Care & Pain Management of New York will NOT be responsible for any health (or other) related problems that result from your refusal to have your health information shared with any physicians, health care facilities or any other agencies.

_____ I consent to release of ALL portions of my medical record to other physicians, healthcare facilities or agencies.

SIGNATURE _____ DATE _____

Relationship to patient if applicable _____

Please put your initial (not and X or check mark) on the appropriate "yes" or "no" line.

NO	YES	
_____	_____	We may send billing statements or letters to your home address
NO	YES	We may send clinical information (labs or xrays) to your home Address
_____	_____	
NO	YES	We may answer emails with any relevant clinical information
_____	_____	
NO	YES	We may call your home phone and identify ourselves.
_____	_____	
NO	YES	We may leave messages on your phone. If so list that number Here _____
_____	_____	
NO	YES	We may call your business phone number and identify ourselves As Advanced Spine Care & Pain Management of New York.
_____	_____	
NO	YES	We may call your cell and identify ourselves as Advanced Spine Care & Pain Management of New York.
_____	_____	

ADVANCED SPINE CARE & PAIN MANAGEMENT OF NEW YORK may speak with the following person/ people regarding any aspect of your healthcare (health records), billing, appointment scheduling if the listed person calls this office to speak to one of our personnel or alternatively if we reach this person when calling you.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT NAME _____

PATIENT SIGNATURE _____