

**AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION**

**MAY WE LEAVE DETAILED VOICEMAIL MESSAGES?**

\_\_\_\_\_ Yes, at this phone number: ( \_\_\_\_\_ ) \_\_\_\_\_

Initial

\_\_\_\_\_ No, please only leave a message asking me to call back.

Initial

**PLEASE DISCLOSE MY PERSONAL HEALTH INFORMATION TO:**

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

\_\_\_\_\_ Spinal Diagnostics may disclose ANY information to this person(s).

Initial

\_\_\_\_\_ Spinal Diagnostics may disclose LIMITED information to this person (s).

Initial

\_\_\_\_\_ Appointment information

Initial

\_\_\_\_\_ Other Specific Information: \_\_\_\_\_.

Initial

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

\_\_\_\_\_ Spinal Diagnostics may disclose ANY information to this person(s).

Initial

\_\_\_\_\_ Spinal Diagnostics may disclose LIMITED information to this person (s).

Initial

\_\_\_\_\_ Appointment information

Initial

\_\_\_\_\_ Other Specific Information: \_\_\_\_\_.

Initial

I authorize Spinal Diagnostics to disclose my personal health information to the person(s) names on this form. I understand that my personal health information may be re-disclosed by the person(s) and may no longer be protected by law.

I have the right to take back (“revoke”) my authorization at any time, in writing, except to the extent that Spinal Diagnostics has already acted based on my permission.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_