Barrow
BRAIN AND SPINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information: (please print)

Patient Name: _____Date of Birth:_____
Social Security Number: _____-_____-_____ Phone Number:_____
Address:_____

I authorize **Barrow Brain and Spine** to: ☐ Release ☐ Receive (select one) information to/from:

Name:_____
Address: _____

City, State, Zip Code:_____
Phone Number:_____ Fax Number:_____

☐ Records to be mailed

☐ Secure E-Mail through the Patient Portal E-Mail Address _____

☐ Records to be picked up by:_____ Date of pickup_____

Information to be Released:

Provide information in my medical records for date(s) of service: From:_____To _____

☐ All medical records ☐ History & Physical ☐ Office Visit Notes ☐ Laboratory Tests ☐ Consultation Reports

☐ X-Rays/Imaging Reports ☐ Billing Records ☐ Other/Specific Information:_____

Information created within _____ month(s) after the date this authorization is signed, as well as past information may be released upon request. **If I fail to specify a time period above; only information created within six (6) months after the date this authorization is signed will be released**.

Purpose of the Release is:

☐ Continued Patient Care ☐ Worker's Comp ☐ Insurance Coverage or Payment for Care ☐ Personal Use

☐ Attorney's Office ☐ Other (please specify): _____

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for the records to be released.

***EXCLUDE the following information from the records release:** (please initial)

____ Drug/Alcohol abuse treatment and/or diagnosis ____ Sexually Transmitted Diseases treatment and/or diagnosis ____ HIV/AIDS testing, treatment and/or diagnosis ____ Mental Illness or Psychiatric treatment and/or diagnosis

Notice: Barrow Brain and Spine and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

My Rights: I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time, with some exceptions, provided that I do so in writing and submit the request to Medical Records. The revocation will take effect when Barrow Brain and Spine receives it, except to the extent that Barrow Brain and Spine or others have already relied on it. For more detailed information on when I can and cannot revoke this Authorization, I can read the Barrow Brain and Spine Notice of Privacy Practices. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I am entitled to receive a copy of this Authorization.

Expiration of Authorization: Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____. **If I fail to specify an expiration date, event or condition, this authorization will expire automatically six (6) months from the date signed**. I understand the matters discussed on this form. I release Barrow Brain and Spine, its employees, agents, officers, directors and medical staff members from any legal responsibility for the disclosure of the above information to the extent indicated and authorized herein. ***There may be a reasonable charge for copies of your medical records.***

Signature:

_____ Date of Signature:_____

Signature of Patient or Legally Authorized Representative Date

_____ Date of Signature:_____

Printed Name of Patient or Legally Authorized Representative

If signed by Legally Authorized Representative; State your relationship to the patient and your authority to act for patient (please attach evidence, if appropriate). If requesting records **from** Barrow Brain and Spine please mail, fax, e-mail as an attachment *(please note email is not a secure method for transmitting sensitive information)* or deliver this form in person to:

Barrow Brain and Spine
Attn: Medical Records
2910 N. Third Avenue
Phoenix, AZ 85013
FAX: (602) 264-2417

nsamedicalrecords@barrowbrainandspine.com