# HIPAA Authorization for Release of Information

NewSouth NeuroSpine, LLC 2470 Flowood Dr Flowood, MS 39232

**Section A: Name and Locations**

I hereby authorize the disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ Date of Birth: _____/_____/_____

Social Security: _____

Practice providing the information:

NewSouth NeuroSpine

2470 Flowood Dr

Flowood, MS 39232

Please send the information to:

_____
Name

_____
Street

_____
City, State, Zip Code

**Section B: Must be completed for all authorizations**

1. Please send the: ☐ Entire medical record ☐ Last 3 years ☐ Last 5 years
2. Other Limitations (please specify, if any):_____
3. Purpose of disclosing the information: ☐ Insurance ☐ Attorney ☐ Doctor ☐ Personal

**Section C: Patient rights and signature**

I understand that my records may contain information regarding the diagnosis or treatment of all my medical conditions in the possession of the practice indicated above and may include confidential information such as that about the diagnosis or treatment of conditions such as HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or psychological conditions. I give my specific authorization for these records to be released. I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time by writing to the medical practice at the address indicated above. I understand that once the health information that I have authorized to be disclosed reaches the indicated recipient that other persons or organizations may re-disclose it, at which time it may no longer be protected under Privacy Laws. A photocopy of this authorization is to be considered as valid as the signed original document. I understand that I must provide documents to prove authority to sign on behalf of someone other than myself and may be required to provide proof of identity at the time of signature.

_____ _____/_____/_____

Signature of patient or patient's representative (Form MUST be completed before signing)

Date

THIS AUTHORIZATION IS VALID FOR FIVE (5) YEARS UNLESS ANOTHER DURATION IS SPECIFIED UNDER SECTION B (2).

Printed name of patient's representative: _____

Relationship to the patient: _____