NEVADA
ORTHOPEDIC & SPINE CENTER
www.nevadaorthopedic.com

# HIPAA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

## Patient:

Name of Patient / Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

## Authorizes:

Name of Health Care Provider / Plan / Other _____

Street Address _____

City, State Zip Code _____

## To Release to:

Name of Health Care Provider / Plan / Other _____

Street Address _____

City, State Zip Code _____

*Format to be provided*: _____ **printed copy** _____ **electronic copy** *Dates of Service:* _____ to _____

**Information to be released:**

___ Office Visits
___ In Office X-Ray Images ($15.00 charge applied)
___ Consultations
___ Procedure Reports
___ Laboratory Results
___ Diagnostic Results
___ Entire Record
___ Billing
___ Medications
___ Other (Specify): _____

**Purpose of disclosure:** _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

**Your rights with respect to this authorization:**

1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "Authorizes" entity above. 3) I understand a photocopy of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. 5) I understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of: Alcohol, Drug Abuse and/or Psychiatric records, Sexually Transmitted Disease and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information, or obtain copies of my health information, by contacting the Privacy Officer.

**Expiration Date:** This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**Signature of Patient or Legal Representative:** _____ **Date:** _____

If signed by other than the patient, select authority and provide documentation:

___ Parent of minor child ___ Power of Attorney ___ Representative of Deceased's Estate ___ Representative of Incapacitated Adult ___ Other

Witness: _____

Revised 5/4/2015 AST