BELLEVUE SPINE SPECIALIST
AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

The fee for providing a copy of your medical record release is $20.00 per patient

Patient Information:

Name_____ Date of Birth __ _____

Previous Name_____Patients Phone#_____

Information Sent to or released to:

I request and authorize BELLEVUE SPINE SPECIALIST to release health care Information about the patient named above to:

Name_____ _____

Address_____ City_____ State_____ Zip_____

Telephone Number ( ) _____

Information to be released:

_____Entire Bellevue Spine Specialist Record Other (please specify)_____

Purpose for which disclosure is being made:

_____Attorney _____Insurance _____Doctor _____Personal _____School

Patient Authorization:

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment or HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

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

_____Drug/Alcohol abuse/treatment&diagnosis _____Sexually transmitted disease
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric or Treatment

My Rights:

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

To take part in a research study, or
To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. I understand that once Bellevue Spine Specialist discloses health care information, the person or organization that receives it may redisclose it, at which time it may no longer be protected under Privacy Laws.

_____

Signature of patient or patient's legally authorized representative Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

_____

Office Use Only

Recorded in Medical Record:_____Doctor:_____Date:_____Reason:_____

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