North American Spine

The Leader in Minimally Invasive Spine Care

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ DOB: _____ Phone Number: _____

MRI/CT Facility: _____ Date of Service: _____ Phone Number: _____

Pain Management Doctor: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Physical Therapist: _____ Phone Number: _____

Chiropractor: _____ Phone Number: _____

I authorize Physician/Facility to release the following information from my records to:

> **North American Spine**
> **Attn: MRI Review Dept**
> Fax: 866.810.6692
> Email: info@northamericanspine.com
> Mail: 8080 Park Lane, Suite 400, Dallas, TX 75231

Information to be released:

☐ Entire Record ☐ Medical Records ☐ Billing Records ☐ Other _____

Purpose of Disclosure: The purpose of need for this disclosure is:

☐ Further Medical Care ☐ Changing Physicians ☐ Insurance ☐ Other _____

☐ Personal Use ☐ Research ☐ Attorney

I understand that my records are confidential and may not be disclosed without my written authorization, except when otherwise permitted by law. I understand this Authorization is voluntary and I may refuse to sign it. I understand I will be charged and must pre-pay fees for the labor and cost of copying the records and postage. I understand the information to be released may include AIDS/HIV test results and diagnosis and treatment; drug screen results and information about alcohol and drug use and treatment; mental health, sexually transmitted diseases and genetic information.

This authorization will expire one year from the date of patient's signature. I have the right to revoke this Authorization at any time in writing. Revoking this Authorization does not affect any action that has been previously taken in reliance on it. I understand information disclosed by this Authorization may be subject to redisclosure by the recipient named above and may no longer be protected by federal or state law. I understand that treatment or eligibility for care cannot be conditioned on my signing this Authorization.

_____ Date _____

Patient or Personal Representative's Signature

_____

Printed Name of Patient or Personal Representative

☑ By checking this box I authorize the use of my electronic signature.

_____

Relationship to Patient