



TRIANGLE SPINE AND BACK CARE CENTER

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Authorization to Use and Disclose or Request Health Information

For Office Use Only
Chart No: _____

Patient: (Please print name) _____ DOB: _____ Date: _____

Authorized Representative: (Printed name) _____ Time: ___ a.m. ___ p.m.

I authorize Triangle Spine and Back Care Center (TSBCC) to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipients(s) of that information. I specifically authorize any current employee, medical provider, or owner of TSBCC to disclose my protected health information as described on this form to the recipient(s) listed. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected under federal law. I also understand that I retain the right to revoke this authorization, if done so in writing and according to the revocation instructions provided upon my request.

___ Patient's entire medical record. (Only information created by TSBCC will be disclosed).

Description of information to be used/disclosed - please be specific:

Other: _____

Specific Name(s) or Class of Recipient(s), YOU MUST provide the correct mailing address(s)/phone & fax number(s)

This authorization permits TSBCC to send protected health information ONLY to the Recipient(s) and the addresses or fax numbers below: Any other address or fax number is not permitted by this authorization.

Recipient #1/ Request from: _____

Address: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

Recipient #2/ Request from: _____

Address: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

Purpose for disclosure - required or information cannot be forwarded

If we are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed Authorization;
You may inspect a copy of the protected health information to be used or disclosed;
You may refuse to sign this Authorization; and
We must provide you with a copy of the signed Authorization.

(Check one) ___ I fully understand and accept the terms of this authorization:
___ I fully understand, but do not accept the terms of this authorization - DO NOT SIGN THIS FORM IF NOT ACCEPTING TERMS

Patient Signature or Parent /Guardian Signature of Minor
Date _____

Authorized Representative Signature
Date _____

Description of Representative's Authority (Limitations)

Please indicate choice for expiration of this authorization:
___ 180 days from signature ___ One year from signature
___ One-time only release or request

This authorization shall expire on _____.
After this date, TSBCC WILL no longer use or disclose your information without obtaining a new authorization form.

will expire _____ period reasonably needed to complete the request.