



# Patient Authorization Request Form

For Office Use Only

Chart No: \_\_\_\_\_

Date Received: \_\_\_\_\_

You may give Triangle Spine and Back Care Center (TSBCC) written authorization to disclose your protected health information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. Note: there will be a charge for copies of your medical records. **Completion of this form will not change the way that TSBCC communicates with your referring and/or family physicians, insurance companies (private or worker's compensation), or with any physician or facility you may be referred to for further medical care and/or testing.**

Patient's Name: \_\_\_\_\_  
Last First Middle Name

Patient's Address: \_\_\_\_\_  
\_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SSN#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year OPTIONAL

Patient's Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient's Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Other#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**At my request, I authorize TSBCC to disclose my Protected Health Information to.** (List the name of the person/entity who will receive your PHI):

Recipient's Name: \_\_\_\_\_  
Last First Middle Name

Recipient's Address: \_\_\_\_\_  
\_\_\_\_\_

Recipient's Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Recipient's Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Other#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Receiver's Relationship to the Patient: \_\_\_\_\_

**Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: 1) your date of birth, 2) SSN, 3) home phone number, and 4) your password or number code.**  
(Note: Use a password easy for you to remember!) Password or Number: \_\_\_\_\_

**I authorize TSBCC to disclose the following PHI to the person/entity listed above. Check ALL boxes that apply:**

- Upcoming appointments
- Current treatment plan
- Current work status
- Medication records
- Test results
- Billing information

Other: \_\_\_\_\_

**If you want to authorize someone to have access to your mental health, substance abuse, or sexually transmitted disease(s) information, i.e. Sensitive and Confidential Information, you must fill out a different form. Please ask the Receptionist for the Authorization to Use and Disclose Sensitive and Confidential Protected Health Information form.**

I would like this authorization to be come effective:

As of the date of receipt by TSBCC       As of: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I would like this authorization to expire on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **OR**  when released from formal follow up.

(If no expiration date is provided, this authorization will expire (12) months from the date of receipt.)

Patient by signature understands:

1. I may revoke this authorization at any time IN WRITING to TSBCC. However, if I revoke this authorization, I understand that the revocation will NOT affect any action TSBCC has taken in reliance on this authorization before revocation is received.
2. I also understand that TSBCC will not condition the provision of treatment per this authorization.
3. I also understand that when my PHI is used or disclosed as authorized by me that the information may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If Signed by a Personal Representative: \_\_\_\_\_  
Print Your Full Name

Describe your authority as a representative to act on behalf of the patient (e.g. power of attorney, court order, parent of minor child, etc.):

\_\_\_\_\_  
\_\_\_\_\_

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to this office.

Return this Authorization via mail:

Or:

Fax: 919-876-7163

Attention:      Medical Records  
                    Triangle Spine and Back Care Center  
                    3320 Wake Forest Road, Suite 430  
                    Raleigh, NC 27609

Attention:      Medical Records  
                    Triangle Spine and Back Care Center

**NOTE:      There will be a charge for copies of your medical records and payment is required prior to release.**