



3320 WAKE FOREST RD. SUITE 430 ~ RALEIGH, NC 27609
919.876.7676 PHONE 919.876.7163 FAX

AUTHORIZATION TO COMMUNICATE OR DISCLOSE HEALTH INFORMATION

For Office Use Only
Chart Number: _____

I, _____ DOB: _____ authorize Triangle Spine and Back Care Center to communicate or disclose my protected health information to me via:

Phone (____) _____	Leave Message?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Phone (____) _____	Leave Message?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Phone (____) _____	Leave Message?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mail: _____
Address _____
City _____ State _____ Zip Code _____

Email: _____
Please Note: We will only communicate by email that we are attempting to contact you and are unable to reach you by the other methods listed above. We would request that you in turn please contact us by phone or mail.
We will not communicate any health information through email.
_____ @ _____

My protected health information may also be discussed with the following individual (s):

NAME _____	RELATIONSHIP _____
NAME _____	RELATIONSHIP _____
NAME _____	RELATIONSHIP _____

Patient Signature: _____ **Date:** _____

* This authorization can be revoked at any time by my request in writing