



## Authorization to Obtain and Use or Disclose Information for Purposes Requested by Patient or Physician's Office

I, \_\_\_\_\_, hereby authorize **Atlanta Brain and Spine Care** to (check those that apply):

\_\_\_\_\_ obtain and use the following protected health information from, or

\_\_\_\_\_ disclose the following protected health information to:

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_

[Specifically describe the information to be obtained and used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This protected health information is being obtained and used or disclosed for the following purposes: [List specific purposes here.]

\_\_\_\_\_ Personal Use

\_\_\_\_\_ Medical Reasons

\_\_\_\_\_ Other (please list): \_\_\_\_\_

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## Authorization to Obtain and Use or Disclose Information for Purposes Requested by Patient or Physician's Office

This authorization shall be in force and effect until **[specify date or event that relates to the patient or the purpose of the use or disclosure]** \_\_\_\_\_ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Privacy Officer** at **2001 Peachtree Road Suite 575, Atlanta, GA 30309**. I understand that a revocation is not effective to the extent that **Atlanta Brain and Spine Care** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

**Atlanta Brain and Spine Care** will not condition my treatment, payment or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under state or federal law.
- Refuse to sign this authorization

The use or disclosure requested under this authorization \_\_\_\_\_ **will** \_\_\_\_\_ **will not** result in direct or indirect remuneration (payment) to **Atlanta Brain and Spine Care** from a third party.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Relationship to patient (or other authority to serve)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date