Spine Care of North Texas
8080 Independence Pkwy, Ste 230
Plano, TX 75025
Ph: 469.998.2273 (CARE)
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Email: records@spinecareofnorthtexas.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI):

Patient Name: _____ **DOB:** _____

Street Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

I authorize Spine Care of North Texas, PLLC to disclose my protected health information to those listed below:

Name	Relationship	Phone

The protected information to be disclosed is (please circle and fill in applicable):

Entire Medical Record

Only information relating to: _____

Only information occurring from: _____ to _____

Other (Specify): _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practices' Privacy Officer. I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that, except as otherwise provided in this authorization, the Practice may use or disclose my protected health information in accordance with the Practices' Notice of Privacy Practices.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations.

I understand that the Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information to disclose to a third party.

Patient Signature (or Personal Representative): _____ **Date:** _____

Printed Name: _____ **Personal Representative's Authority:** _____

The Authorization provided with this signature will expire in one year from the signature date. Spine Care of North Texas will require an updated form after this.