PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: __/__/__ Patient Telephone#: ( )_____-_____ Date of Birth_____

I _____ hereby authorize Long Island Spine Specialists, P.C., to disclose my entire
Patient's full name
Information file to: ❑ Myself – I will pick up ❑ Please mail my records to my home.

❑ Other: _____

SPECIFIC INFORMATION TO BE USED AND/OR DISCLOSED

❑ Office notes, x-rays, procedure reports, diagnostic reports
❑ You may discuss my medical file (Entire Health Information) with the following (name and relationship.

1.) _____
2.) _____
3.) _____

✦ ***Please read the following carefully before signing at the bottom.***

I understand that if my records contain information relating to my sexually transmitted disease, acquired immunodeficiency syndrome, (AIDS) or human immunodeficiency virus (HIV) related information; such information will be released pursuant to this authorization. Confidential HIV related information indicating that an HIV test was done; HIV is present; HIV related illness, or AIDS; or any information concerning drug or alcohol abuse and/or treatment, or behavioral, mental illness services, or psychiatric treatment; such information will be released pursuant to this authorization.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this information, I must do so in writing and present my written revocation the medical facility. I understand that the revocation will not apply to information that has already been released in response this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to ensure treatment. I understand that I may inspect or copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the Federal Confidentiality Rules may not protect the information.

If I have any questions about disclosure of my health information, I can contact LISS at (631) 462-2225

X_____ DOB___/___/_____ SS#: _____/_____/_____
Patient Signature

X _____ X _____
PARENT/GUARDIAN WITNESS