MendelsonKornblum
Orthopedics, Spine & Pain Specialists

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ hereby authorize _____ its Director or Designee, or Health Information Management/Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any; behavioral medicine services record, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis. HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below:

1. Name of person(s) or organization(s), to which information is to be released to:

Name _____ Phone _____

Street Address _____

City _____ State _____ Zip Code _____

I understand that my protected health information disclosed under this authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

2. Specific type of information to be disclosed:

- ☐ Assessment/Evaluation Notes
- ☐ Appointment Schedule
- ☐ Treatment Progress Notes
- ☐ Discharge Summary
- ☐ Treatment Logs
- ☐ Other: _____

3. The purpose and need for such disclosure (please mark):

- ☐ Employer Request
- ☐ Consultation
- ☐ Attorney
- ☐ Disability Certification
- ☐ Social Service
- ☐ Personal Use
- ☐ Continuation of Care
- ☐ Insurance Application
- ☐ Research
- ☐ Social Security
- ☐ School Requirement
- ☐ Other _____
- ☐ Insurance Claim
- ☐ Worker's Compensation

4. This authorization may be revoked, in writing, at any time except to the extent that information has already been released or disclosed. We will not condition treatment or payment based upon this Authorization or Revocation of Authorization unless otherwise allowed by law.

Patient Name _____ Maiden/Other Name _____

DOB _____ Social Security # XXX-XX- _____

Address/City/State/Zip _____

Patient Signature _____ Date _____

Consent of legal guardian, patient advocate or personal representative if patient is incapable or is a minor.

Representative Signature _____ Date _____

Relationship _____ Witness _____

5. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date signed below, or time period specified by patient.