NORTHWEST SPINE SURGERY

Specializing in Neurological Surgery of the Spine

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date Of Birth:_____ Phone:_____

Address:_____ City/State/Zip:_____

Please RELEASE Information FROM:

Northwest Spine Surgery
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Bret G. Ball, MD, PhD
10000 SE Main, Suite 360
Portland, OR 97216
(P) 503-253-4000 or (F) 503-253-4002

Please RELEASE information TO:

Name_____
Street Address_____
_____
City/State/ZIP_____
Phone_____
Fax_____

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS: _____

_____

For the Purpose of: ____ Patient Care ____ Insurance ____ Claim Self Other: _____

List specific dates of records to be released: _____

Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows: _____ (date or event.)

The following must be INITIALED by the requestor to be included in the use and/or disclosure:
____*HIV/AIDS related information and/or records ____ Mental Health Information ____Genetic Testing information ____ **Drug/alcohol diagnostics, treatment, or referral information authorized by law.

*This information may not be re-disclosed without the specific written authorization of the individual, except where

** Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature: _____ _____

(Patient/legal representative) Date

If signed by other than patient, indicate relationship: _____