SpineOne

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION ("Authorization")

(INCLUDING VERBAL DISCUSSION OF HEALTH INFORMATION)

GENERAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____

_____ DOB: ___/___/____

I hereby authorize the following Affiliated Covered Entity (choose appropriate entity below) including its agents and employees (collectively the "Healthcare Provider"):

☐	**SpineOne, Inc.**	8500 Park Meadows Dr, #200 Lone Tree, CO 80124	303-500-8611
☐	**Denver Metro Imaging, LLC**	8500 Park Meadows Dr, #050 Lone Tree, CO 80124	303-925-0674
☐	**The Surgery Center at Lone Tree, LLC**	8500 Park Meadows Dr, #100 Lone Tree, CO 80124	303-951-7510
☐	**Park Meadows Anesthesia, LLC**	8500 Park Meadows Dr, #100 Lone Tree, CO 80124	303-986-4190

to use or disclose "protected health information" of **(insert patient name below):**

_____ (the "Patient"), covered under privacy regulations and any amendments thereto issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule") as specified in this Authorization. I understand that "protected health information" may include records by other health care providers and facilities who previously provided treatment to the Patient.

INFORMATION TO BE USED OR DISCLOSED:

I specifically authorize the Healthcare Provider to use or disclose the following (collectively the "Patient's Health Information and Records") (select appropriate boxes below):

☐ Entire Medical Record ☐ Most Recent 3 Years of Medical Record ☐ Medical Billing Records

☐ Imaging Studies (e.g., x-rays, photographs, MRIs, CTs, etc.) ☐ Laboratory & Diagnostic Reports

☐ Substance Use Records Only (alcohol/drug abuse information) ☐ HIV/AIDS related information

☐ OTHER _____

Please specify a date range for the above selected Patient's Health Information and Records if applicable:

From _____ To _____

Lastly, I specifically authorize the Healthcare Provider to discuss, clarify, and provide explanation of the Patient's Health Information and Records to the Recipient(s) described below.

Person(s) Authorized to Make the Use or Disclosure:

I hereby authorize the Healthcare Provider to make the uses and disclosures specified in this Authorization.

Recipient(s) of Use or Disclosure:

The Patient's Health Information and Records may specifically be used by or disclosed to

_____

If the recipient is an entity, then the Patient's Health Information and Records may also be used by or disclosed to that entity's agents and employees. Furthermore, for the purposes of treatment, payment, and operations, the Patient's Health Information and Records may also be used by or disclosed to healthcare providers the Patient is referred to, payors, and to current and past healthcare providers including but not limited to the Patient's primary care physician, pharmacist, etc.

Purpose(s) of the Use or Disclosure:

The purpose of the use or disclosure (other than for treatment, payment, and operations) is to provide the Patient's Health Information and Records at the request of the individual signed below.

Additional Statements:

This authorization will expire twelve (12) months from the date signed below.

I understand that I may revoke this Authorization by submitting a written revocation to the Healthcare Provider. However, such revocation will not be effective with respect to any use or disclosure made by the Healthcare Provider in reliance on this Authorization before the Healthcare Provider received my revocation.

I understand that this Authorization is voluntary and that the Healthcare Provider cannot condition the Patient's treatment, eligibility, or benefits on whether or not I sign this Authorization.

I understand that the Patient's Health Information and Records (except for Substance Use Records) used or disclosed by the Healthcare Provider pursuant to this Authorization may be subject to redisclosure by the recipient(s), in which case the Patient's Health Information and Records might no longer be protected under the HIPAA Privacy Rule.

I hereby release the Healthcare Provider from any liability, damages, and expenses arising in connection with the use or disclosure of the Patient's Health Information and Records pursuant to this Authorization. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

Patient Name | Date

Patient Signature

Or, if applicable

Personal Representative | Date

Basis of Personal Representative's authority to sign for Patient

[NOTE: YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.]