Premier Spine Care, P.A.

7900 College Blvd, Suite 137, Overland Park, KS 66210 · Phone (913) 322-2700 · Fax (913) 322-7890

AUTHORIZATION TO RELEASE HEALTH INFORMATION

1 Patient

Patient's full name _____ Other names used (maiden, previous) _____

Date of birth _____ Phone _____ Email _____

Street address _____ City, state, ZIP _____

2 Who sends and who receives *(check one)*

☐ Premier Spine Care, P.A. may send my health information to the person or organization below.

☐ The provider or organization below may send my health information to Premier Spine Care, P.A.

Name of the person or organization _____ ☐ This is me (the patient)

Address _____

Phone _____ Fax _____ Email _____

3 Information to release *(check all that apply)*

☐ Complete medical record ☐ Office and clinic notes ☐ History and physical

☐ Consultation reports ☐ Operative reports ☐ Imaging reports

☐ Imaging studies (images on CD) ☐ Laboratory results ☐ Hospital discharge summaries

☐ Physical therapy records ☐ Work status and restrictions ☐ Billing records

☐ Other: _____

Dates of care: from _____ To _____ ☐ All dates

4 Specially protected information

Federal and state law require my specific permission to release the information below. It is released only if I check the box AND write my initials beside it. Psychotherapy notes are never released with this form.

☐ HIV/AIDS testing or treatment Initials _____ ☐ Mental or behavioral health Initials _____

☐ Alcohol or drug use treatment Initials _____ ☐ Genetic testing Initials _____

5 Purpose of the release *(check all that apply)*

☐ At my request ☐ Continuing medical care ☐ Legal matter

☐ Insurance or workers' compensation claim ☐ Disability application ☐ Other: _____

6 How to send it

☐ Mail ☐ Fax ☐ Secure email ☐ I will pick it up

7 Expiration

This authorization expires on (date or event) _____

If left blank, it expires one year from the date I sign it.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

8 My rights

- Signing is voluntary. Premier Spine Care will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this form.
- I may look at or get a copy of the information to be released, and I will receive a copy of this form.
- I may cancel this authorization at any time by writing to Premier Spine Care, P.A., Attn: Medical Records, 7900 College Blvd, Suite 137, Overland Park, KS 66210, or by fax to (913) 322-7890. Cancelling does not affect information already released.
- Once released, the information may be shared again by the person or organization that receives it, and may no longer be protected by federal privacy law, unless the recipient is a health care provider or health plan covered by that law. Federal and state law may still limit the sharing of alcohol and drug treatment, HIV/AIDS and mental health information without my further written permission.
- A reasonable fee for copies may apply, as allowed by law.

9 Signature

Signature of patient or legal representative _____ Date _____

Printed name _____

If signed by a legal representative (parent of a minor, legal guardian, power of attorney), please complete the lines below and include a copy of the document that gives you this authority.

Representative's name _____ Relationship to the patient / authority _____

Representative's phone _____ Representative's address _____

FOR OFFICE USE

Date received _____ Date sent _____ Sent by _____ Method _____