Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

I authorize the practice below to release my health information:

Interventional Spine Associates of the Carolinas
1918 Randolph Rd
Suite 820
Charlotte, NC 28207
Fax # 704-980-6955 Phone # 704-980-6000

Please forward/release my health information to:

_____

_____

_____

_____

ISA may release the following information:

☐ Entire Record ☐ Financial Records ☐ Office Visit Notes

☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.

☐ Diagnostic Studies ☐ On site record review by patient

☐ Other: _____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete:

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____Date _____

Signature of Patient or Personal Representative

_____Date _____

Description of Personal Representative's Authority (attach necessary documentation)

Revised: April 2015