CENTER FOR CRANIAL & SPINAL SURGERY

Authorization For Release of Information

PATIENT NAME: _____ _____
LAST **FIRST** **MI** **MAIDEN OR OTHER NAME**

DATE OF BIRTH: ____-____-____ **SSN :** ____-____-____
MO **DAY** **YEAR**

ADDRESS:_____**CITY:**_____**STATE:**_____**ZIP:** _____

DAY PHONE (**)**____ - _____ **EVENING PHONE (** **)** ____-_____ **CELL (** **)** ____-_____

I hereby authorize HealthPort Technologies agent for The Center for Cranial & Spinal Surgery, PC or The Center for Cranial & Spinal Surgery, P.C. to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

DATES:

- ❑ History and physical exam _____
- ❑ Progress notes _____
- ❑ Lab reports _____
- ❑ X-ray reports _____
- ❑ Other: _____ _____

I specifically authorize the release of information relating to:

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

X _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE:
❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care
❑ Legal ❑ School ❑ Insurance ❑ Workers Compensation
❑ Other (please specify): _____

1. I understand that this authorization will expire **within 60 days** after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by _____ (Print Name of Provider) for the purpose of:
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that The Center for Cranial & Spinal Surgery, PC will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Virginia Code 80.01-413, I will pay a fee for said copies. There is no charge for medical records if copies are sent directly to facilities for ongoing care or follow up treatment. ***There is a fee for permanent transfer of your records to another facility or for personal copies.***

_____ _____ OR _____ _____
SIGNATURE OF PATIENT **DATE** **PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON** **DATE**

_____ _____ _____
RECORDS RECEIVED BY **DATE** **RELATIONSHIP TO PATIENT**

FOR CCSS OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____

MEDICAL INFORMATION RELEASED BY

ENTIRE _____ LAB _____ EKG _____ __
DS _____ EKG _____ IMMUNE _____ __
OP _____ XRAY _____ OTHER _____
HP _____ PATH _____
NUMBER OF PAGES _____

_____
CCSS Staff Member

_____ 20____
DATE