



The Spine Care Center & Spine Care Associates

Restoring Function. Relieving Pain.

www.spinecareva.com
8525 Rolling Rd Suite 200
Manassas, VA 20110
Tel: 703-257-2266
Fax: 703-257-2269

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

(Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office)

I, _____, hereby authorize The Spine Care Center: to
(check those that apply):

_____ use the following protected health information; and /or

_____ disclose the following protected health information to: _____

This protected health information is being used or disclosed for the following purposes:
(be specific)

This authorization shall be in force and effect until _____ at
which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by
sending such written notification to PRIVACY OFFICER, The Spine Care Center, 8525
Rolling Road, #200, Manassas, VA 20110.

I understand that a revocation is not effective to the extent that The Spine Care Center has
relied on the use or disclosure of the protected health information.



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I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

The Spine Care Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

1. Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
2. Refuse to sign this authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to The Spine Care Center from a third party (if applicable).

Signature of Patient or Patient Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority