The Spine Care Center & Spine Care Associates

Restoring Function. Relieving Pain.

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PERMISSION TO DISCLOSE INFORMATION

Print Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the above named patient.

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

I understand that if the person that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization and can be addressed to the company listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) of infection with HIV regulated by Federal Statute (42 CFR Part 2)

Signature of Patient, Parent or Guardian: _____ Date: _____

(This authorization will expire one year from date of signature)