SPINAL DIAGNOSTICS

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AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

MAY WE LEAVE DETAILED VOICEMAIL MESSAGES?

_____ Yes, at this phone number: (_____) _____
Initial

_____ No, please only leave a message asking me to call back.
Initial

PLEASE DISCLOSE MY PERSONAL HEALTH INFORMATION TO:

Name: _____

Phone number: _____

_____ Spinal Diagnostics may disclose ANY information to this person(s).
Initial

_____ Spinal Diagnostics may disclose LIMITED information to this person (s).
Initial

_____ Appointment information
Initial

_____ Other Specific Information: _____.
Initial

Name: _____

Phone number: _____

_____ Spinal Diagnostics may disclose ANY information to this person(s).
Initial

_____ Spinal Diagnostics may disclose LIMITED information to this person (s).
Initial

_____ Appointment information
Initial

_____ Other Specific Information: _____.
Initial

I authorize Spinal Diagnostics to disclose my personal health information to the person(s) names on this form. I understand that my personal health information may be re-disclosed by the person(s) and may no longer be protected by law.

I have the right to take back ("revoke") my authorization at any time, in writing, except to the extent that Spinal Diagnostics has already acted based on my permission.

Signature: _____ Date: _____