HIPPA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name	**Patient's Date of Birth**
Address	**Patient's Telephone Number**
City, State, Zip	**Any Other Names Used**

I hereby request that SonoSpine® use/disclosure of my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1 From the following facilities and/or providers (list all)

2 Be sent to the following person/entity at the address below:

3 I authorize disclosure of the following specific information (include dates of service)

4 I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **Unless otherwise specified below, I understand that my PHI will be provided in paper format.**

5 I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.

6 I understand I may revoke this authorization by notifying SonoSpine® in writing of my desire to revoke it.

7 My purpose/use of the information is for: Personal use; or other (please specify) _____

8 This authorization expires on _____ ___, 20__, OR upon occurrence of the following event that relates to me or the purpose of the intended use or disclosure of information about me (please specify):_____

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING, INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ _____

Signature of Patient **Date of Patient's Signature**

_____ _____

Legal Guardian or Representative **Date of Legal Guardian or Representative**

_____

For SonoSpine® Use Only

Date Received: _____

MRN: _____

Date Processed: _____