# Authorization to Release Healthcare Information

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**3390 Peachtree Rd. NE Suite 1500**
**Atlanta, GA. 30326**
**Ph: (770) 929-9033 Fax: (770) 929-9092**

Patient Name: _____ Date of Birth: _____/_____/_____

Phone Number: _____ Email: _____

I hereby request and authorize Alliance Spine and Pain Centers, P.C. to:
(Please check one)

☐ **RELEASE** **OR** ☐ **OBTAIN**

the protected health information relating to the diagnosis, care and treatment of the above named patient

Person/Institution: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

The type of information to used or disclosed is as follows (check all that applies):

☐ All medical records ☐ Medical Records from: ____/_____/_____ to ____/_____/_____

☐ Other (please specify): _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I under that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION OF DISCLOSURE: Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal Regulation [42 CFR Part 2] prohibits recipients from making any further disclosure of this information except with specific written consent to the patient. DIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by state regulations without the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for this purpose.

RE-DISCLOSURE: Notice is hereby given to the patient of legal representative signing this authorization that Interventional Spine & Pain Management cannot guarantee that the recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the re-disclosure of any health information regarding drug and alcohol abuse, HIV or mental health treatment.

_____ _____ _____
Patient signature Date signed Witness