

Medical Records Request and/or Release Authorization

I hereby authorize Advanced Back and Neck Care Center to:

Please choose all that apply: **Release** my health information to **Obtain** my health information from

Provider/Facility Name: _____

Address: _____ Phone: _____ Fax: _____

Protected Health Information to be sent to/obtained from Advanced Back and Neck Care Center:

- Examination Reports Printed X-ray imaging reports Digital X-ray imaging on a disc
 Reports and records from other physicians Billing Records Other _____

Copies of the information described above for the period of _____ to _____

Method of delivery: Mail Fax Secure Email Patient Pickup

The patient or their representative may revoke this authorization by notifying ABNCC's designated Privacy Officer in writing. Federal Law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal law requires a statement informing you that protected health information released under this authorization may be subject to re-disclosure by the recipient. This medical records request and/or release authorization shall expire exactly five years from the signature date indicated below.

I am fully aware of my right under HIPAA regulations and have signed a copy of Advanced Back and Neck Care Center's Notice of Privacy Practices. I have discussed any concerns I have with the release, use or disclosure of my protected health information with ABNCC's Privacy Compliance Officer and/or other appropriate office personnel.

I understand that the following protected health information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug use; or similar conditions of a sensitive nature.

I understand that ABNCC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release ABNCC from all legal liability that may arise from authorization.

I authorize this information to be transmitted by way of ground parcel, fax, certified mail, electronic or direct delivery to be sent to or obtained from Advanced Back and Neck Care Center.

By signing this form below, I authorize Advanced Back and Neck Care Center to use, receive, release or disclose the below indicated protected health information.

Patient Name: _____ Signature: _____

Date of Birth: _____ Date Signed: _____