Authorization to Disclose Protected Health Information

Patient Name: ________________________ Date of Birth: ________________________

Phone: ______________________________ Email: ______________________________

Release information from:

Name Of Facility: Coastal Spine Institute, PC

Release information to:

Name Of Facility/Address: ____

Email: ______________________________ Fax: ______________________________

Purpose of release:

___ Personal Use ___Continuity of Care ___Disability ___Other

CSI records to be released:

____

____

I direct and hereby authorize Coastal Spine Institute, PC to delivery the Protected Health Information specified in this Authorization to the party or parties specified in the following medium, if available:

___ Hardcopy format, such as paper or facsimile (fax)

___ Electronic format, such as CD-Rom or flash drive (memory stick)

___ Email

___ No format preference.

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of CSI. I agree to

assume such risks personally, and to hold CSI harmless in the even my Protected Health Information is breached or compromised as a result of my directing and authorizing CSI to transmit or deliver such information electronically.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notice to CSI. This authorization shall be in force and effect until the expiration date listed below, at which time this authoriation shall expire.

I understand that a revocation is not effective to the extent that CSI has relied on this information for the use or disclosure of the Protected Health Information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

____

Name of Patient or Personal Representative

____

Signature of Patient or Personal Representative

____

Date Signed

____

Authorization Expiration Date

____

Description of Personal Representative's Authority