# Atlantic Brain and Spine, P.A.

## Standard Authorization of Use and Disclosure of Protected Health Information

**Information to Be Used or Disclosed/Purpose of Disclosure**

I hereby authorize the following disclosures: ☐ **ALL** (or those individually selected below)

- ☐ Billing Information
- ☐ Diagnostic Test Reports
- ☐ Discharge summary
- ☐ Discuss/Schedule appointments
- ☐ Drug, Alcohol, Substance abuse Records
- ☐ Genetic Information
- ☐ HIV/AIDS Test Results
- ☐ Lab Results
- ☐ Mental Health Records
- ☐ Operative Reports
- ☐ Past/Present Medications
- ☐ Patient Allergies
- ☐ Physicians Orders
- ☐ Pick up Prescriptions
- ☐ Progress Notes
- ☐ Radiology Reports and images

**Persons to Whom Information May Be Disclosed**
Information described above may be disclosed to:

| Name of person/organization | Phone # | Relationship to Patient |
|---|---|---|
| Name of person/organization | Phone # | Relationship to Patient |
| Name of person/organization | Phone # | Relationship to Patient |

**Expiration Date of Authorization:** This authorization is effective through the current calendar year and will be renewed annually.

**Right to Terminate or Revoke Authorization:** You may revoke or terminate this authorization by submitting a written revocation to Atlantic Brain and Spine, P.A., attention HIPAA Privacy Officer. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Atlantic Brain and Spine, P.A. discloses it to another party.

**Rights of the Individual:** You may inspect or copy information used or disclosed under this authorization.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative/Relationship to Patient

ABS