CAROLINA
NeuroSurgery & Spine
ASSOCIATES

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

Name: _____ DOB: _____ MRN: _____

Carolina Neurosurgery & Spine Associates is authorized to discuss my protected health information (PHI) with the individual(s) I have indicated below.

(Choose one or all of the *options below)

Last Name	First Name	DOB	Relationship	*Appointments	*Billing/ Financial	*Medical Record
1.				☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
2.				☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
3.				☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

***Appointments – c**onfirm any appointment date, time and/or location, reason for visit, and authorization to schedule or cancel visits
***Billing/Financial -** account balance, itemized statements, change in billing information, make a payment, etc.

***Medical Record -** includes but is not limited to appointment date and time, verbal disclosure of entire record set including information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral / mental health services, treatment for alcohol/ drug abuse and other conditions.

_____ **I DO NOT** give permission for my PHI to be discussed with anyone other than myself.

During emergent and/or extreme situations, CNSA may not have access to this authorization, but will make all reasonable efforts to protect your PHI when discussing your care. Please allow up to 5 business days from the date of receipt by CNSA to update your PHI Disclosure information.

Rights of the Patient:

- I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information (PHI) to be disclosed in this document by sending written notification to CNSA. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective moving forward.
- I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization and that my treatment is not conditional on this document.
- I understand that requests for my PHI from any entity other than the individual(s) listed above may require the completion of a separate authorization form as required by Federal and/or State law or as a compliance policy of Carolina Neurosurgery & Spine Associates.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ _____
Print Patient/Authorized Representative name Date

_____ _____
Signature Patient/Authorized Representative Date