AUTHORIZATION TO RELEASE OR REQUEST PROTECTED HEALTH INFORMATION

I, (print full name of patient) ____DOB_______________ Contact #

_________________________Mailing Address ____

hereby authorize

Carolina Neurosurgery & Spine Associates (CNSA)
1130 N. Church St. Ste. 200, Greensboro NC 27401
Phone 336-272-4578 Fax 336-272-5931

To: ____ **RELEASE** information from my medical record **TO** **OR** To: ____ **REQUEST** information **FROM**

(**LIST AUTHORIZED ENTITY BELOW**)

Provider/Organization/Individual____

Address:____

Phone:____Fax:____

IMPORTANT NOtICE: This is a FULL release, including drug, alcohol, psychiatric and sexually transmitted disease information UNLESS listed here:

Treatment Dates (Specify Date or Date Range):

____

_____Entire record ______Medication list ______Other (please specify below)

_____History & Physicals ______Imaging Reports ____

_____ Office visit notes ______ Hospital notes ______Films on CD (Acquire through Imaging Department)

Purpose of Release: ___Legal ___Changing physicians ___ Insurance ___Personal use ___ Disability

___ Workers' Compensation ___ Other:_______________ (Please describe)

*** THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE BELOW UNLESS AN EXPIRATION DATE IS INDICATED HERE: ____/____/______**

Your records may include records or partial records from other providers; however CNSA is not responsible for the completeness or accuracy of those records. We provide them merely as a convenience to you. You are responsible for obtaining those records directly.

NOTICE TO PATIENTS: The patient or the patient's representative may inspect and/or copy the health information disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at any time. **A copy of this authorization will be made available to you upon your request**. Your treatment and/or billing is not conditional on this authorization being signed except in the specific circumstances allowed by the HIPAA Privacy Rule. We cannot protect against the possibility that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by law.

____ ___________ _______________

Signature of Patient/Parent/Legal Guardian/Authorized Person Date Relation to Patient

PLEASE READ: A fee may be charged to make copies of the requested medical record. We contract with DataFile Technologies to provide medical records requested from our office. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.CNSA/Datafile – HIPAA – PHI Release – 01-14-2014