WELLNESS
BRAIN & SPINE
Stanley H. Kim, MD

Authorization for Release of Protected Health Information (PHI)

Patient Name Date of Birth

_____/_____

Address Telephone / Cell

_____/_____/_____

I hereby authorize (name of facility/provider releasing information) to disclose the above-named individual's health information:

_____

_____

Name (facility releasing information) Address City State Zip

_____

_____

Telephone Number Fax Number

Date(s) of Service Requested (if known) or Provider: _____

_____

Description of information to be released: (check all that apply)

____ Progress Notes
____ Consultations
____ Most recent history & physical
____ Laboratory Reports
____ Radiology/Imaging reports
____ Immunization record
____ Other
____ Entire medical record

_____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

_____

This information may be disclosed to and used by the following individual or organization (receiving the information)

_____

_____

Name (Facility receiving information) Address City State Zip

_____

Telephone Number Fax Number

_____

Description of the purpose of the use and/or disclosure: (check one)

____ Continuing Care
____ Collaboration of Care
____ Confidential Legal Purposes
____ Second Opinion
____ Emergency/Acute Care
____ Personal Use
____ Social Security/Disability
____ Insurance
____ Other_____

_____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. Wellness Brain & Spine may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____) day or event.

I further understand that I may revoke this authorization at any time by notifying Wellness Brain & Spine. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect my actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient or Patient's Representative Date

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