vista HEALTHCARE

SOUTHWEST SPINE & PAIN CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

Please select one or both of the following or specify other instructions:

O I hereby authorize Southwest Spine and Pain/Vista Healthcare to **release records to the providers listed on page two**	O I hereby authorize Southwest Spine and Pain/Vista Healthcare **to obtain records from the providers listed on page two**

O Other (please specify instructions): _____

I request and authorize the named health care provider(s) (see page 2) to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released may include information regarding the following conditions(s) which may be protected by Federal Law, Drug/ Alcohol Abuse, Mental Health Problems, Sickle Cell Anemia, HIV/AIDS Infection, Sexually Transmitted Diseases.

INFORMATION TO BE RELEASED:

Dates of Service: _____

- All chart records
- Consultation(s)
- Operative Report(s)
- Pathology Report(s)
- Radiology Report(s)
- Laboratory Report(s)
- Billing Information
- Other (specify) _____

FOR THE PURPOSE OF:

- Further Medical Treatment
- Moving/ Relocation
- At the request of the individual
- Insurance claims
- Attorney/ Court Case
- Change Physicians
- Other (specify) _____

Confidential notice: The documents accompanying this release contain confidential information belonging to the sender. This information is legally privileged and intended for the use of the individual named above, if you are not the intended recipient, please notify the sender and dispose of the information you received. Use of this protected information by anyone other than the recipient is strictly prohibited. The request will expire 12 months from signature date.

_____ _____

Signature of Applicant **Date**

Prepared by: ☐ Patient ☐ Parent of Minor Child ☐ Legal Guardian

The Southwest Spine and Pain/Vista Healthcare may disclose or obtain health information to or from the following recipient(s):

1. Name (or title) and organization _____

   Address _____

   City _____ State _____ Zip _____

   Phone _____ Fax _____ Email _____

2. Name (or title) and organization _____

   Address _____

   City _____ State _____ Zip _____

   Phone _____ Fax _____ Email _____

3. Name (or title) and organization _____

   Address _____

   City _____ State _____ Zip _____

   Phone _____ Fax _____ Email _____

4. Name (or title) and organization _____

   Address _____

   City _____ State _____ Zip _____

   Phone _____ Fax _____ Email _____

5. Name (or title) and organization _____

   Address _____

   City _____ State _____ Zip _____

   Phone _____ Fax _____ Email _____

6. Name (or title) and organization _____

   Address _____

   City _____ State _____ Zip _____

   Phone _____ Fax _____ Email _____

Patient Name (Printed): _____ DOB: _____ Signature: _____