the SUMMIT
Institute for Orthopedics, Spine & Human Movement

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Proudly Physician Owned

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Previous /Maiden Name:_____

Date of Birth: _____ SSN: _____ Address: _____

City: _____ State/Zip: _____ Phone Number:_____

I authorize the use or disclosure of the above named individual's health information as described below:

FACILITY TO RELEASE RECORDS:

Name: _____

Address: _____

Phone: _____

Fax/Email: _____

FACILITY TO RECEIVE THE RELEASED RECORDS:

Name: _____

Address: _____

Phone: _____

Fax/Email: _____

Purpose of Disclosure: _____

The information to be disclosed: (**please check the information you want released**): Treatment Date Range: _____To:_____

	Rehabilitation Office Notes		Summit Surgical Laboratory Report(s)
	Mirage imaging X-ray & MRI Reports		Summit Pain Management Records:
	Mirage imaging X-Ray & MRI Films		Complete Health records from (entity name):
	Summit Surgical Op note		Other:
	Summit Surgical Pathology Report(s)		Other:

The information disclosed may include matters regarding mental health, alcohol or drug abuse and infectious diseases, including AIDS or HIV test results. Such information may be subject to special protections. If you do not wish such information to be released, list information to be excluded here: _____

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to: HIPAA Privacy Officer, at The Summit. This authorization expires on _____ (date or event) or within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the Privacy Regulations. A photo static copy of this authorization shall be considered as effective and valid as the original authorization. I also understand fees may be charged for preparing and sending copies of records including charge for labor and supplies up to $18.97 per request and a copying charge of up to $0.63 for the first 250 pages and $0.45 for additional pages (K.S.A 65-4971(b)).

_____ _____ _____

Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, Relationship to Patient: _____

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The Summit is Physician Owned Facility for Exceptional Healthcare

For Office Use Only: Records sent _____, 20___, By: _____
(Date) (Initials)