New England Sport and Spine

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www.nesportandspine.com

Authorization to Release HealthCare Information

Patient Name: _____

Date of Birth: _____ **Telephone:**_____ **SSN:**_____

I authorized New England Sport and Spine;

□ **To give my health information to:** _____
Name

□ **To receive my health information from;**_____
Name

Street	**City/Town**	**State**	**Zip**

Specify information to be released:

I release the above information for the purpose or purposes of:

□ **Ongoing treatment/aftercare** □ **At the request of the individual**

□ **Other**_____

I understand that:

- **I understand that signing this authorization is not a condition to treatment, payment, enrollment, and eligibility for benefits.**
- **I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage, or a claim for health benefits or other insurance or other adverse consequences.**
- **I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated and signed notification to the facility indicated above except to the extent that New England Sport and Spine has already acted in reliance on it.**
- **I am entitled to a copy of this authorization, upon request.**
- **I understand that this information may be re-disclosed by the recipient and therefore no longer protected by the privacy laws.**
- **I can cross out any provision on this form with which I disagree.**
- **There may be a charge to cover the copying cost.**

State and Federal laws require my specific consent to disclose any of the following information;

Circle one response for each of the four statements below:

I DO I DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. If I authorize the release of such information, I understand that it cannot be re-disclosed by a recipient without specific consent.

I DO I DO NOT authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.

I DO I DO NOT **wish to review this information before it is released**. **I understand any such review must be supervised and an appointment will need to be made where the files are currently located.**

I DO I DO NOT authorize the disclosure of information which refers to treatment or diagnosis of HIV infection, ARCS, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

I DO I DO NOT authorize future disclosures regarding these records to the same individuals and/or entities.

_____ _____

Signature of Patient Date

_____ _____

Signature of Authorized Representative Relationship

THIS RELEASE MUST BE FILLED OUT COMPLETELY-PLEASE READ CAREFULLY

This release is valid for 12 months from date of signature