Advanced Spine & Pain Clinics of MN®

Patient's Consent to Disclose Protected Health Information to an Authorized Person

Patient's Legal Name _____ Date of Birth _____

o I authorize Advanced Spine and Pain Clinics of MN, LLC to use and disclose the protected health information described below to an individual known as:
Name: Relationship: Phone number:

_____

Extent of Authorization

- ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
- ☐ I authorize the release of my complete health record except for the following information: Mental health records, Communicable diseases (including HIV and AIDS), Alcohol/drug abuse treatment,

Purpose of Disclosure:

- ☐ This medical information may be used by the person I authorize to receive this information for participation in my medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Termination and Revocation Rights.

- ☐ This authorization shall be in force until I revoke this authorization in writing to the Privacy Officer at Advanced Spine and Pain Clinics of MN.

Benefits.

- ☐ I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Disclosure.

- ☐ I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Acknowledgment of Reading and Agreement:

I have read and understood this authorization.

_____

Patient Signature or Representative Representative's Authority Date

_____

Printed Name

EMAIL: refer@tcpaindoctor.com Fax: 612-315-4473 or mail to: 2801 So Wayzata Blvd Minneapolis, MN 55405

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED