

**NeuroSpine Institute, L.L.C.**

**74B Centennial Loop, Suite 100, Eugene, OR 97401**

**Telephone (541) 686-3791 Facsimile (541) 686-3795**

**AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION**

I authorize NeuroSpine Institute, L.L.C. (LLC) to use and disclose a copy of the specific health and medical information described below regarding:

\_\_\_\_\_  
*(Last Name of Patient) (First Name of Patient) (Middle Name of Patient) (Date of Birth)*

consisting of: \_\_\_\_\_  
*(Describe information to be used/disclosed)*

to: \_\_\_\_\_  
*(Name and address of recipient or class of recipients)*

for the purpose of: \_\_\_\_\_  
*(Describe each purpose of disclosure or state "at the request of the individual" if this Authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)*

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- \_\_\_\_ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
- \_\_\_\_ By initialing here, I specifically consent to the disclosure of my mental health information.
- \_\_\_\_ By initialing here, I specifically consent to the disclosure of my genetic testing information.
- \_\_\_\_ By initialing here, I specifically consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

If we, the health care provider, are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- (1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- (2) You may inspect a copy of the protected health information to be used or disclosed;
- (3) You may refuse to sign this Authorization; and
- (4) We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.

This Authorization will expire on the earlier of \_\_\_\_\_ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose

**I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or Patient's Representative)*

Description of Representative's Authority: \_\_\_\_\_

For Official Use Only  
Received by: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or Patient's Representative)*