New York Spine & Wellness Center

Attention Medical Records
5496 East Taft Road, North Syracuse, NY 13212
Fax #: 315-552-6701

AUTHORIZATION FOR NYSWC TO RELEASE/ DISCLOSE YOUR PHI

This form is so we may release records to someone other than yourself at your request.
This is not the correct form to request records for yourself.

I authorize New York Spine and Wellness Center to disclose my protected health information ("PHI") to the individual or entity named below. This authorization form is voluntary; New York Spine and Wellness Center will not condition my treatment on the signing of this authorization form.

Please Complete the Following Information
(Failure to complete this form in its entirety will result in a delay in processing your records)

1. **Patient Information (Please Print)**

_____
Name: Last First Middle **Date of Birth**

_____
Address: Street Address City State Zip Code

2. Individual or Entity Authorized to Receive PHI: Please provide the name and address of the Individual or Entity to whom you are authorizing New York Spine and Wellness Center to disclose your PHI:
(This can be family members, another doctor's office and or friends. **If you would like your PHI to be disclosed to an attorney, a written request must be submitted by the attorney**)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____Fax#_____

3. Description of PHI to be Disclosed: Please indicate the *specific PHI* to be disclosed (e.g., lab results; x-ray reports; specific dates of service; entire medical record; etc.):

_____

_____

_____

4. Reason for Disclosure: List specific reason for disclosure of the above stated PHI **("At the request of the individual**" is acceptable if the request is made by the patient and the patient does not want to state a specific purpose)

_____

_____

5. Expiration Date: This authorization shall become effective immediately, please choose an expiration date
   - □ No expiration date
   - □ Upon completion of requested disclosure
   - □ On _____/_____/_____ (indicate specific date)
   - □ Other _____

(Indicate date or event on which the authorization shall expire)

Completion of form on side 2

Right to revoke authorization: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 5496 East Taft Rd, North Syracuse, NY 13212. I understand that a revocation is not effective to the extent that New York Spine and Wellness Center has already relied upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA privacy regulations.

Dated: _____

_____ _____

Signature of Individual Printed Name of Individual

_____

If this Authorization is to be signed by a Personal Representative of the Individual, please complete the following:

_____ _____

Signature of Personal Representative Printed Name of Personal Representative

Description of authority: _____

(A personal representative must provide legal proof of representation, e.g., guardian, health care proxy, power of attorney)

Please Note: If your protected health information contains HIV-related information the New York State Department of Health requires the attached Authorization for Release of Confidential HIV-related Information be completed.

A copy must be given to the pt.

We will respond to requests for copies within 30 days if the information is located within our facility and within 60 days if the information is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request

For office use only

_____	_____	_____
Signature of Staff Fulfilling the request	Signature of staff verifying records	Date Request Completed