AA Spine & Pain Clinic

4100 Lake Otis Parkway Suite 208 & 216
Anchorage, AK 99508
Phone 907 563-2873 Fax 907 563-5852
aapain.com

Authorization for Use/Release of Health Information

Name:				Phone:	
Date of Birth:		Age:		S.S. #:	

I Hereby Authorize AASP to Release Information to:					
Person/Agency:					
Address:					
City:		State:		Zip:	
Phone #:		Fax #:			

I Hereby Authorize AASP to Obtain Information from:					
Person/Agency:					
Address:					
City:		State:		Zip:	
Phone #:		Fax #:			

HIPPA requires that only specificied records be released			**Required** *(please tick YES or NO for each line)*				
Yes	No	Office Notes		Yes		No	Procedures
Yes	No	Medications		Yes		No	Hospital
Yes	No	Labs		Yes		No	All Records
Yes	No	Radiology		Yes		No	Other: ______________________

______________I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar condition. This does not indicate that I have these conditions but allows the release of the records without review.

______________ I have been provided a copy of **AA Spine & Pain Clinic's** Notice of Privacy Practices and any changes that may be associated with this authorization. I have discussed any concerns. I may have about the use, release, and disclosure of my health information disclosed under this authorization. I release **AA Spine & Pain Clinic** from any legal liability that may arise from this authorization.

______________The patient or their representative may revoke this authorization by notifying in writing **AA Spine & Pain Clinic's** designated Privacy Officer. Federal Law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient.

Signature of Patient or Representative:		**Date:**	
Relationship to Patient:		**Witness:**	

Expiration date: 1 year from date signed

**AA Spine and Pain Clinic records will be provided on CD. The first copy each year will be provided at no charge. Additional copies are $25 each.*

Last Modified: February 2015