AUTHORIZATION TO DISCLOSE INFORMATION

Date:_________________________

For information about how your medical information may be used or disclosed, please see the patient notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of Southern Spine Specialists. The notice is also posted at Southern Spine Specialists.

YOU MAY REFUSE TO SIGN THIS FORM: HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU MAY HAVE REQUESTED. WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

By my request, I hereby authorize Southern Spine Specialists to disclose information regarding my treatment, insurance issues and payment issues to the people listed below. These individuals will be asked to identify themselves and state the patient's social security number and zip code.

Name (please print)	Relationship (please print)
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

I understand that this authorization is voluntary. I understand that the person to whom I authorize disclosure of my personal data is not a health plan, health care provider or clearinghouse and that the released information, in their possession may no longer be protected by federal privacy regulation. I understand that I may withdraw my authorization in writing to the Privacy Officer of Southern Spine Specialists at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire 10 years from this date. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.

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Signature of patient or patient's representative Date

Printed name of patient's representative____

Description of the Representative's authority to act for the patient____________________________