AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (LAST, FIRST		DOB
ADDRESS		**SSN**
CITY	**STATE**	**ZIP**

SOUTHERN BRAIN & SPINE
3798 VETERANS BLVD
SUITE 200
METAIRIE, LA 70002

NAME		
RECORDS DEPOSITION SERVICE		
ADDRESS		
120 WEST MADISON STREET, SUITE 300		
CITY	**STATE**	**ZIP**
CHICAGO	IL	60602
ATTENTION:		

This authorization will expire on the following date or event. If date or event are not indicated, authorization will expire within 12 months from date signed.

Date: **Event:**

Purpose of this Disclosure:
LEGAL

Description	Start Date	End Date
☐ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other: RADIOLOGY IMAGES		

The following information will be released when included in the above information unless you indicate otherwise:

☐ AIDS or HIV test results ☐ Psychiatric or mental care / treatment

☐ Alcohol, drug or substance abuse treatment ☐ Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE RECIPIENT IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	**Date:**
Signature of Representative (if necesary):	**Date:**
Personal Representative's Relationship to Patient:	