Disclosure of Protected Health Information

According to our office policy, test results or the release of medical information will be provided to the patient only. Please specify below whom information may be released to other than you. Please complete the information and sign below to verify your permission. **Please circle all that apply and fill in the blanks:**

Do we have permission to leave messages on your voicemail? Y N

Do we have permission to discuss medical information with a family member? Y N *If yes, please list below

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Alternate Contact Name: _____ Relationship _____

Phone: _____ Alternate Phone: _____

Advanced Directives

It is the right of every adult citizen in Tennessee (18 years and over) to sign a living will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices that you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure that your provider has a copy for your file.

Authorization

I authorize Southeastern Spine release any insurance company, managed care organization, state or federal agencies, centers for Medicare and Medicaid services, Third Party Administrators, and/or Worker's Compensation (or it's agents) any information needed to process my claim and/or determine benefits payable for related services. I also authorize Southeastern Spine to utilize a fax machine to transmit any/all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Southeastern Spine to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other benefits be made on my behalf to Southeastern Spine. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment benefits apply.

Patient or Guarantor Signature _____ **Date** _____