APEX SPINE INSTITUTE

821 Swift Blvd.
Richland, WA 99352
Ph: 509-606-5040
Fax: 509-946-7253

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Medical Record Number**

Address | **Patient's Date of Birth**

City, State, Zip Code | **Patient's Telephone Number**

I hereby authorize **VERBAL** use or disclosure of entire patient file for patient described above. This authorization does not serve as a release of medical records. Any medical records requests will need to be submitted in writing.

The following may receive disclosure of entire patient file as described above:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
I may revoke this authorization by notifying Apex Spine Institute in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires five years from date of signing.

Signature of Individual*
(The person about whom the information relates)

Date of Individual's Signature

Date of Birth

OR, if applicable –

Signature of Guardian or Personal Representative of Patient's Estate

Date of Guardian's/Personal Representative's Signature

Description of Authority to Act for the Individual