EAST BAY BRAIN & SPINE
MEDICAL GROUP

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFOMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and Records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Patient Name:	Patient DOB:	Date:

AUTHORIZATION

I hereby authorize EAST BAY BRAIN & SPINE MEDICAL GROUP to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

This form gives EAST BAY BRAIN & SPINE MEDICAL GROUP permission to discuss your protected health information (PHI) with others for healthcare purposes.

This authorization is:

_____ Unlimited
(all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment)

_____ Limited to the following medical information

- _____ History & Physical Progress Notes
- _____ Lab Reports
- _____ Medication Records
- _____ Operative/Hospital Reports
- _____ Radiology Reports
- _____ Other (X-ray/ MRI/MRA/ CT or Bone Scan films)

I also consent to the specific release of the following records:

Patient Initials

_____ Drug/Alcohol/ Substance Abuse

_____ Psychiatric Mental Health

_____ Tests for Antibodies to HIV

_____ HIV Diagnosis/Treatment

_____ Genetic Information

DURATION

This authorization shall be effective immediately and remain in effect
☐ indefinitely or ☐ until: _____ (date).

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*
_____	_____	_____
Printed Name of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Witness Signature*	*Date/Time*