Shepherd Center

**SHEPHERD SPINE AND PAIN INSTITUTE**

Complete the attached Medical Release Form and submit:

By Email: painreferrals@shepherd.org

By Fax: (404) 603-4418

By Mail: Shepherd Spine and Pain Institute
ATTN: New Patient Coordinator
2020 Peachtree Road, NW.
Atlanta, Georgia 30309

If you have any questions, please contact our New Patient Coodinator at (404) 603-4203 or painreferrals@shepherd.org

Shepherd Center
SHEPHERD SPINE AND PAIN INSTITUTE
2020 Peachtree Road, NW
Atlanta, Georgia 30309
(404)350-7493

Patient Name: _____

SSN: _____

Date of Birth: _____

Med. Rec. #: _____

## AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize: _____

_____

to use or disclose (a copy) of my health information as identified below to Shepherd Spine and Pain Institute,
Attn: New Patient Coordinator; fax 404-603-4418; 404-603-4203

for the follwing purposes: [X] Continuing Care and Treatment [ ] Insurance Claim [ ] Legal
[ ] Personal Use [ ] Other, describe _____

By initialing the spaces below, I specifically authorize the use and disclosure of the following health information and/or medical records, if such information and/or mecial records exist:

___ Discharge Summary/Discharge Note X History/Physical Exam X Consultation Reports
___ Progress Notes ___ Physician Orders ___ Nurses' Notes X Laboratory Reports
X Diagnostic Imaging Reports ___ Therapy Notes, describe _____
___ Billing Statements _____

*** ___ Entire Medical Records Including Nurses' Notes *** ___ Entire Medical Records Including Nurses' Notes

Other: Procedure Reports and Operation Notes
_____

Specify Period of time for which authorization applies: _____

IF THIS AUTHORIZATION IS FOR THE USE OR DISCLOSURE OF PSYCHOTHERAPY INFORMATION, THEN IT CANOT BE COMBINED WITH ANY OTHER AUTHORIZATION.

___ Psychotherapy Progress Notes ___ Psychotherapy Physician Orders ___ Psychotherapy Evaluation

Other (describe) _____

Specify Period of time for which authorization applies: _____

## Certain Other Health Information for Use or Disclosure

I understand that for certain information to be disclosed, state or federal laws and regulations require my specific written authoization as follows (please initial to verify authorized use or disclosure)

___ HIV/AIDS related health information

___ Genetic testing information and/or records

___ Mental health information and/or records

___ Drug/alcohol diagnosis, treatment or referral information

Federal regulations require a description of how much and what kind of information is to be disclosed.
Describe information for use or disclosure:

___ Dictation Physician Reports ___ Progress Notes ___ Physician Orders ___ Lab and/or Other Diagnostics

___ Other (describe) _____

___ Specify period of time for which authorization applies: _____

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I understand that if the person or entity recieving the information is not a health care provider or health care plan coverd by federal privacy regulations, the information described above and on the reverse side of this page may be redisclosed and no longer protected by these regulations. The recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality requirements.

I understand that the person I am authorizing to use or disclose the information may receive compensation for doing so. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be use or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of the signing or until _____.

_____ _____

Signature of patient or patient's legal representative | Date

_____

Print name of Patient

_____ _____

Print name of patients legal representation if applicable | Relationship to patient

___ Patient is unable to sign authorization but gives verbal approval for the use or disclosure of health information as described in this authorization.

Reason patient is unable to sign authorization: _____

_____ _____

Signature of witness | Date

_____

Print name of witness