



## Release of Protected Health Information

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Previous name: \_\_\_\_\_ Account #: \_\_\_\_\_

### I. Authorization

- For \_\_\_\_\_ to disclose my health care information to Interventional Spine and Rehabilitation of Louisiana/ Dr. Mark John.
- For Interventional Spine and Rehabilitation of Louisiana/Dr. Mark John to disclose my health care information to:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### II. You may use or disclose the following health care information:

- Entire Contents of Record
- Only the Following Content (specify):  
\_\_\_\_\_

### IV. Purpose of this authorization:

- At my request
- Relocation
- For Insurance Change
- Other: \_\_\_\_\_

### V. This authorization ends one year from the date signed below.

### VI. My Rights:

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization in writing by sending a letter to the health care provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the health care provider based upon this authorization.
- I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that once the health care provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.

**\*\*This request form can be mailed or faxed to Interventional Spine and Rehabilitation of Louisiana.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Individual legally authorized to sign on behalf of the patient

\_\_\_\_\_  
Representative's authority to act for patient