INTERVENTIONAL
SPINE & REHAB
OF LOUISIANA

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MARK JOHN, M.D.
PHYSICAL MEDICINE & REHABILITATION
INTERVENTIONAL PAIN MANAGEMENT

Release of Protected Health Information

Patient Name: ______________________________ Date of Birth: ____________________
Previous Name: ______________________________ Account Number: ____________________

I. Authorization

- ☐ For ________________________________ to disclose my health care information to Interventional Spine and Rehabilitation of Louisiana / Dr. Markus V. John.
- ☐ For Interventional Spine and Rehabilitation of Louisiana / Dr. Markus V. John to disclose my health care information to any treating physicians and/or possible treating physicians.

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

- ☐ Entire contents of record
- ☐ Only the following contact (specify):

  ____

  ____

III. Purpose of this authorization:

- ☐ At my request
- ☐ Relocation
- ☐ For insurance change
- ☐ Other: ____

  ____

IV: This authorization ends one year from the date signed below

V. 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 this authorization is directed. If I did, it would not affect my 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 HIPPA 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

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