DISC
DESERT INSTITUTE FOR SPINE CARE
1635 E. Myrtle Avenue, #400
Phoenix, AZ 85020
Tel: 602-944-2900
Fax: 602-944-0064

Authorization to Discuss, Release and/ or Obtain Medical Information

Patient Name:_____ **Date of Birth:** _____ **Email:** _____

Address:_____ **Preferred Phone:** _____

- **I hereby authorize Desert Institute for Spine Care, PC (DISC) to call and/or leave messages on my home phone, cell phone and/or email regarding appointments, referrals, test results, medical care and financial information. I understand that each of these communications is NOT considered completely secure since someone else could access the information. If NOT, please list the exclusion(s): _____ _____.**

- **I hereby authorize DISC to discuss my medical care with the following individuals (i.e. relatives/caregiver):**
  Name:_____Relationship:_____
  Name:_____Relationship:_____

- **I hereby authorize DISC to contact the following individual in case of an emergency:**
  Name:_____ Relationship:_____ Contact Number: (_____)_____-_____

- **I hereby authorize DISC to RELEASE copies of the following medical records:**
  ❒all my medical records ❒last year's medical records ❒other records: _____

  Release my medical records to this Individual/Institution/Physician:_____

  Relationship:_____ Phone: (_____)_____-_____ Fax: (_____)_____-_____
  Address:_____City: _____ St:_____ zip: _____

***** PHYSICIAN AND CONSERVATIVE TREATMENT RECORDS ARE REQUIRED FOR SURGICAL AUTHORIZATION ******

- **I hereby authorize DISC to OBTAIN the following medical records from the physician/institution(s) listed below:**
  ❒all my medical records ❒last year's medical records ❒other records: _____

  Obtain my medical records from this Physician/P.T./Chiropractor/Institution:_____

  Relationship:_____ Phone: (_____)_____-_____ Fax: (_____)_____-_____
  Address:_____City: _____ St:_____ zip: _____

I authorize DISC to send/receive confidential information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996) to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care and as authorized above. I understand DISC may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the DISC Notice Privacy Practices. I may revoke this authorization in writing, except to the extent that we have already used/disclosed your information. I understand if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. You have the right to submit a written request to inspect and copy your medical records. In certain limited circumstances this request may be denied. By signing below, I hereby release DISC from all legal responsibility/liability that may arise from the act I have authorized above.

_____ _____ _____
Name of Patient/Legal Representative **Signature** **Date**