



Name: _____

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize, to a person(s) or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Please list the family member(s) or other persons with names and phone numbers, if any, whom we may inform about your appointments, lab and x-ray results or other healthcare information. Please use the first line for your emergency contact person. I authorize this information to be released verbally or in writing.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Can confidential messages including appointment reminders, lab and x-ray results or other health care information be left on your home answering machine or voicemail? (Circle one) YES NO

If no, please print the telephone number, if any, where you want to receive this information: _____

3. If you do not have voicemail, can a confidential message be left at your place of employment? (Circle one) YES NO

4. I understand that I may revoke or change this authorization at any time by notifying Carolina Spine & Neurosurgery Center in writing. I understand that CSNC has thirty (30) days from the date of receipt of the written revocation to update this information in the system. The revocation will not be valid if CSNC has taken action in reliance on the above authorizations or if this authorization is obtained as a condition for obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I consent to medical treatment and diagnostic procedures by Carolina Spine & Neurosurgery Center healthcare providers. I have read the above Consent to Use or Disclose Information for Treatment, Payment, or Healthcare Operations and do hereby authorize the release/transmission of pertinent medical information necessary for treatment, payment or healthcare operations. I have also read and completed the above Authorization for Use and Disclosure of Individually Identifiable Health Information and understand that if I refuse to sign this authorization, the law may allow CSNC to refuse treatment. I am responsible for all charges incurred at Carolina Spine & Neurosurgery Center and authorize payment of insurance benefits (Medicare, Medicaid or commercial insurance) directly to CSNC. I am responsible for payment of all charges not covered/denied by insurance contracts, including co-payments, deductibles, non-covered services, worker's compensation; and those determined by the insurance company, where there is no contract with CSNC, to be above the insurance company's usual and customary fee.

Signature of Patient or Authorized Representative

Date

CSNC USE ONLY: ACCT# _____ INITIALS/DATE ENTERED _____ PROVIDER# _____
Identity of Authorized Representative was verified by Drivers License # _____
Representative is MPOA/LEGAL GUARDIAN/HOME CARE PROVIDER