

**HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION**

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Print Name _____, Mosenthal Spine Clinic will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**

By signing this authorization you acknowledge and agree that Mosenthal Spine Clinic may use or disclose Medical Records for the purpose(s) of Medical treatment.

By signing this authorization you agree that Mosenthal Spine Clinic or its Business Associates may disclose your personal health care information for treatment.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Mosenthal Spine Clinic HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Mosenthal Spine Clinic has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Mosenthal Spine Clinic at any of its offices or by sending a written request with return address.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Mosenthal Spine Clinic for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Mosenthal Spine Clinic has taken action in reliance on it. A revocation is effective upon receipt by Mosenthal Spine Clinic of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Signature of Participant or Personal Representative

Date_____