ADVANCED MEDICAL
SPORTS & SPINE

Consent for Release of Protected Health Information (PHI)

Patient Name: ____
(person whose information will be released)

Date of birth: __________/_________ /__________

Address: ____

Phone #: _________________________________

I understand that this authorization will allow Advanced Medical Sports and Spine, PLLC and its affiliates to use or disclose the protected health information described below: (Please check only one line)

____ Any and all protected health information Advanced Medical Sports and Spine, PLLC and its affiliates maintains, including mental health, HIV, health status or substance abuse records. This also includes information on health programs, plan information and caregiver resources with the person being authorized including web access when available

____Protected health information about treatment for the following condition or injury, or other information (include dates): ____
____
____
____

I understand I have the right to revoke this authorization at any time by sending written revocation to Advanced Medical Sports and Spine, PLLC.
I understand the revocation will not apply to information that has been released in response to this authorization.
I understand I do not have to sign this authorization and that Advanced Medical Sports and Spine, PLLC cannot base treatment or payment decisions on whether I sign this authorization.
I understand that after the information is disclosed pursuant to this authorization, it can be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

This Authorization grants permission to the Party(s) Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis and prognosis; and have access to my financial health information. This information can be disclosed to, and used by, the following people or organization:

Person or Organization Name: ____
(person or organization information will be released to)

Date of birth: (if applicable) __________/_________ /__________

Address: ____

Email: ____

Phone #: _________________________________

Relationship (circle): Spouse | Sibling | Parent | Child | Agent/Broker | Friend | Organization

Person or Organization Name: ____
(person or organization information will be released to)

Date of birth: (if applicable) __________/_________ /__________

Address: ____

Email: ____

Phone #: ________________________________

Relationship (circle): Spouse | Sibling | Parent | Child | Agent/Broker | Friend | Organization

Person or Organization Name: ____
(person or organization information will be released to)

Date of birth: (if applicable) __________/_________ /__________

Address: ____

Email: ____

Phone #: ________________________________

Relationship (circle): Spouse | Sibling | Parent | Child | Agent/Broker | Friend | Organization

Person or Organization Name: ____
(person or organization information will be released to)

Date of birth: (if applicable) __________/_________ /__________

Address: ____

Email: ____

Phone #: ________________________________

Relationship (circle): Spouse | Sibling | Parent | Child | Agent/Broker | Friend | Organization

Patient or Legal Representative signature: ____

Date: _________/_________ /_________ **Check one:** ___**Patient**___**Legal Representative**

Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.

After you complete and sign the form, please fax it to **(540) 738-0105. OR** If you prefer, mail your completed form to:

Advanced Medical Sports and Spine, PLLC
2002 Orange Road STE #201
Culpeper, Virginia 22701