

# Houston Center for Spinal Reconstruction and Disc Replacement

## Authorization of Use and Disclosure of Protected Health Information

**Appointment Reminders:** The practice may use your information to remind you about up coming appointments. Typically, appointment reminders are done by phone calls with a brief, non specific message left on your answering machine or with someone answering your home phone. If you don't approve of these methods and would like alternative reminder methods please indicate those methods in the space provided.

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Houston Center for Spinal Reconstruction and Disc Replacement? (Check all that apply)

Home Telephone       Cell Phone       Work Telephone

E-mail (include address \_\_\_\_\_)

Fax Machine (include fax number \_\_\_\_\_)

Other: \_\_\_\_\_

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Houston Center for Spinal Reconstruction and Disc Replacement?

Yes       No       Not Applicable

If "NO" how else may we contact you regarding this information?

\_\_\_\_\_

Please list any other restrictions regarding messages or reminders about your healthcare:

\_\_\_\_\_

\_\_\_\_\_

**Other Uses and Disclosures:** Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. All changes must be in writing to our office. You have the right to request restrictions on use and disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:

\_\_\_\_\_

**Persons Authorized to Receive Information:**

Health information Houston Center for Spinal Reconstruction and Disc Replacement collects or receives about you may be disclosed to the following persons:

| Name of Person | Relationship | DOB   |
|----------------|--------------|-------|
| _____          | _____        | _____ |
| _____          | _____        | _____ |
| _____          | _____        | _____ |
| _____          | _____        | _____ |

**Use and Disclosure of Information:**

\_\_\_\_ I authorize the person(s) listed above to receive all health information about appointment, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided by Houston Center for Spinal Reconstruction and Disc Replacement.

\_\_\_\_ I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please specify):

\_\_\_\_\_  
\_\_\_\_\_

**Expiration Date of Authorization**

This authorization is effective today and open ended unless revoked or terminated by the patient or patient’s personal representative if patient is a minor.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Houston Center for Spinal Reconstruction and Disc Replacement. You should contact the Privacy Officer or other authorized representative to terminate this authorization.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient Representative      Date

\_\_\_\_\_  
Signature of Patient      Date

\_\_\_\_\_  
Relationship of Patient Representative to Patient

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***For Office Use Only***

( ) Consent received by \_\_\_\_\_ on \_\_\_\_\_.

( ) Changes made to consent on \_\_\_\_\_ and added to the patient’s medical records.