(NS)² NewSouth NeuroSpine

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Mail to: Attention Medical Records
2470 Flowood Drive
Flowood MS 39232

Email: ns2medicalrecords@ns2.md

Fax: (601) 420-1968

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **CITY/STATE/ZIP**: _____

The undersigned authorizes NewSouth NeuroSpine to release my health information as noted below:

Release to: _____ **Email:** _____

Address: _____ **Phone:** _____

_____

City: _____ **State:** _____ **Zip:** _____ **Fax:** _____

Purpose of Request: ____Personal ____Treatment ____Insurance ____Legal

Information to be released: ___Complete Records ___Last 3 years ___Last 5 years __ X-ray Disc__Billing

Method of release: _____Email _____Fax _____Mail ____Pickup

Pursuant to HIPAA 45CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing the copies. At no time will the cost-based fee exceed MS State Law Statute 11-1-52.
*****Records being sent to another healthcare provider will be sent at no cost.*****

I understand that my records may contain information regarding the diagnosis or treatment of all my medical conditions in the possession of the practice indicated above and may include confidential information such as that about the diagnosis or treatment of conditions such as HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or psychological conditions. I give my specific authorization for these records to be released. I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time by writing to the medical practice at the address indicated above. I understand that once the health information that I have authorized to be disclosed reaches the indicated recipient that other persons or organizations may re-disclose it, at which time it may no longer be protected under Privacy Laws. A photocopy of this authorization is to be considered as valid as the signed original document. I understand that I must provide documents to prove authority to sign on behalf of someone other than myself and may be required to provide proof of identity at the time of signature.

THIS AUTHORIZATION IS VALID FOR FIVE (5) YEARS UNLESS ANOTHER DURATION IS SPECIFIED.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient or Authorized Representative **Date**

For internal use by *NewSouth NeuroSpine* only:

Patient Id#: _____ **Date received:** _____

Date processed: _____ **Processed by:** _____

Fee charged: _____