Spinal Surgery
Micro Surgery
Pain Management

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Neurological Surgery
Computer Guided Surgery

AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purpose.)

Today's Date_____

Patient Name:_____

BY SIGNING THIS FORM, I AUTHORIZE PETER O. HOLLIDAY, III, M.D., PC TO USE, RELEASE OR DISCLOSE THE PROTECTED HEALTH INFORMATION DESCRIBED BELOW TO:

NAME AND ADDRESS OF PERSON/ORGANIZATION TO WHOM INFORMATION SHOULD BE SENT

Organization Name _____ ATTN: _____

Mailing Address _____ City/State/Zip _____

Telephone (_____)_____ FAX (_____)_____

PUROPOSE OF DISCLOSURE: *(i.e. for personal records, continued medical care, employment, disability insurance, V.A., etc.)*

I authorize the following information to be sent to the address/fax # above:

_____Copies of all medical records for the period: _____/_____/_____ to _____/_____/_____ OR

_____Copies of SPECIFIC medical records as described below (such as History and Physical, Lab/X-Ray reports)

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions. I understand that there may be information in these records that I would not want released.

I have been provided a copy of Peter O. Holliday, III, M.D., PC's Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns that I may have about the use, release, and disclosure of my health information with Peter O. Holliday, III, M.D., PC's Privacy Officer or other appropriate personnel.

I understand that Peter O. Holliday, III, M.D., PC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Peter O. Holliday, III, M.D., PC from any legal liability that may arise for this authorization.

Patient Signature _____Date _____ SS#_____ DOB: _____

If the signature above is not that of the patient, I am acting for the patient because:_____

My relationship to the patient is: _____ Signed: _____

The patient or their representative may revoke this authorization by notifying in writing to Peter O. Holliday, III, M.D., PC's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.