MICHIGAN HEAD & SPINE INSTITUTE *Neurosurgery • Physiatry • SOR Physical Therapy • Premier MRI/CT*

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that maybe used/disclosed:_____

_____

2. The information will be used/disclosed for the following purpose(s):_____
3. Persons/organizations authorized to: use or disclose **and/or** receive the information:

   Michigan Head & Spine Institute/Premier MRI/CT Name _____

   29275 Northwestern Hwy, Ste 100 Address _____

   Southfield, Michigan, 48034 City, State, Zip _____
4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 5 and 6 on this form.
5. If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, we reserve the right to deny treatment associated with such research.
6. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, we reserve the right to deny that health care.
7. I understand that I may inspect or copy the information used or disclosed.
8. I understand that I may revoke this authorization at any time by notifying MHSI in writing, except to the extent that:
   (a) action has been taken in reliance on this authorization; or
   (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
9. I understand that I have a right to request and receive a Notice of Privacy Practices.
10. This authorization is valid for information dated prior to and including date form signed unless otherwise indicated.

    MICHIGAN HEAD & SPINE INSTITUTE, PC MAY DISCLOSE INFORMATION ABOUT HIV/AIDS, ALCOHOL and/or SUBSTANCE ABUSE OR MENTAL HEALTH.

    _____**YES** **or** _____ **NO**
11. **There is a charge for copies of Medical Records and/or X-ray films/CD copies.**

ωωω THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING ωωω

_____ _____

Signature of patient or patient's representative Date

_____

Printed name of patient or patient's representative

Representative's authority to act for the patient, if applicable
__Parent of minor under 18 yrs of age
__Court appointed guardian (attach copy of Guardianship papers)

Patient's Date of Birth_____ Social Security #_____ Account #_____