ATLAS SPINAL CARE
16500 SE 15th St Suite 160 Vancouver, WA 98683
Phone (360) 718- 7944
Fax (360) 718- 7931

AUTHORIZATION TO REQUEST HEALTHCARE INFORMATION

*(Patient Name)*_____ *(Date of Birth)*_____ authorizes

Atlas Spinal Care to request my healthcare information from the following entity:

Facility Name: _____ Fax:_____

Address:_____

The following information may be requested: *(Check all that apply)*

☐ All healthcare information in my medical chart including radiology.
☐ Only healthcare information elating to the following injury, illness or treatment:_____
☐ X-Ray's, MRI's, or CT ☐ Report ☐ Disk

I give my authorization to request health care information for the following purposes:
(Check all that apply)

☐ To share information with my health care team in an attempt to coordinate care.
☐ To obtain payment of care expenses I have incurred for my treatments.
☐ To take part in research.
☐ Other:_____

This authorization expires on _____.*(No longer than 90 days from date signed)*

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Atlas Spinal Care. I understand that a revocation is not effective to the extent that Atlas Spinal has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer by protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or refuse to sign this authorization.

Patient Signature:_____ Date:_____