THE SPINE & BRAIN INSTITUTE

Disclosure of Information

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I, _____, give permission for this office to leave detailed messages on the answering machine/voicemail:

☐ My home (please initial) _____ ☐ My cellular phone (please initial) _____

(Initial) _____ I authorize The Spine and Brain Institute to send unencrypted emails from the email provided that may include patient healthcare information.

Disclosure of Information

The physicians at The Spine and Brain Institute are committed to complying with HIPAA regulations. Therefore, we require our patients to sign authorization stating those individuals (s) (family members, friends, etc.) that are approved to hear discussion and obtain patient health information.

TO BE COMPLETED BY THE PATIENT:

I authorize the following individual(s) to be involved in the discussion of and obtain my health information and relieve The Spine and Brain Institute of any responsibility for harmful neglect (release of medical health information) by my authorized individual(s):

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

Patient Name: _____ **D.O.B.:** _____

Patient Signature: _____ **Date:** _____