ASPEN
SPINE & PAIN CENTER

Return Form to: PO Box 17418 Reno, NV 89511

Authorization for Release of Health Information

Patient's Full Name _____ Date of Birth: _____

Address: _____ Telephone: _____

I consent and authorize Kevin Miles, D.O./Aspen Spine and Pain Center to release my Protected Health Information (PHI) as described below.

Release Information To: _____

Telephone: _____ Fax: _____

Address: _____

Purpose of Request to Release PHI:

□ Treatment/Continuity of Care □ Personal/Patient Request □ Legal/Attorney
□ Insurance □ Other (Specify) _____

Delivery Method Requested: □ Mail □ Email _____ □ Fax □ Pick-Up

Dates of Service: _____ To _____

PHI to be Disclosed:

□ Physician Office Reports
□ Physician Operative Reports
□ Laboratory Reports
□ Imagine Reports
□ EMG Reports
□ Billing Records
□ Other: _____

I understand that the disclosed reports may disclose information relating to the my drug, alcohol and substance abuse and communicable diseases, including HIV/Aids. I, the patient, may inspect and obtain a copy of the Protected Health Information, in which I am authorizing the disclosure. I understand I may revoke this authorization at any time, except to the extent that the individual or entity to which the disclosure is to be made, has already fulfilled the request. I also understand that this authorization shall become effective immediately and will remain in effect for one year from the date signed, unless a different date is specified here _____. This authorization will terminate only upon the execution and receipt of my written statement by Aspen Spine and Pain Center, indicating my intent to revoke this authorization.

Patient Signature: _____ Date: _____

Printed Name: _____

_____

Office Use Only: Identification verified by: _____
Verified by: Photo ID Matching Signature Other: _____ 06/18