Permission to Verbally Discuss Health Information

LASER SPINE INSTITUTE®

Patient name:_____Date:_____
Address: _____
City:_____ State:_____ ZIP code:_____
Phone #:_____Email:_____

You may choose to give us permission to discuss information about you with family, friends and others you designate who are involved in your care or are concerned about your health status and may ask about your condition or need information when you are not present. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. **Complete this form to let us know whom we may speak with about your information. Fax back to 813-418-4382.**

Examples of when it might be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions
- If a relative or friend is helping with billing instructions
- If a relative or friend calls to verify an appointment time
- If a relative or friend comes in and asks if you are at our facility, in or out of surgery or the procedure room

If you change your mind when you have another appointment with us, you may complete a new permission form. **You must notify us in writing.**

I authorize Laser Spine Institute to VERBALLY discuss the following information about me with the following, including translation from/to another language:

Name:_____
Address:_____
Work phone:_____ Mobile:_____ Home:_____

Check all boxes that apply:

☐ Appointment information ☐ Medical information, including my symptoms, diagnosis, medication and treatment plan
☐ Lab/test results ☐ Billing and payment information
☐ My location in the facility, whether I am waiting to go into surgery or the procedure room, in recovery or have been released and discharged

This authorization is effective one (1) year from the date signed below, except when revocation or modification is requested in writing by the patient, legal guardian, power of attorney or health care surrogate accompanied by the applicable documentation. I understand that I have the right to revoke or modify this authorization at any time. I understand that if I revoke or modify this authorization, I must do so in writing and present my written request to _____ and the Privacy Officer at Compliance@LaserSpineInstitute.com. Additionally, I acknowledge my responsibility to confirm receipt by LSI of such revocation or modification; such confirmation is required via certified mail. I understand that the revocation or modification will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected under federal privacy laws or regulations.

Signature needed

_____

Signature of patient/authorized representative Date