Neurology Partners, P.A., dba
Emas Spine and Brain Specialists
(904) 448-4180 • Fax (904) 448-4184
www.emasspineandbrain.com

Authorization to Use or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name: **Date of Birth** **SSN**

Address **Telephone**

The following individual or organization is authorized to make the disclosure:

☐ Emas Spine and Brain Specialists ☐ Other (Please Specify)____

This information may be disclosed to and used by the following individual or organization:

Emas Spine and Brain Specialists • 4085 University Blvd. • South Suite 3 • Jacksonville, FL 32216

Treatment Dates: Purpose of Request

The following information is to be disclosed (Please check all that apply)

Yes	No		Yes	No	
☐	☐	Physician Notes	☐	☐	X-ray Reports
☐	☐	Complete Record	☐	☐	MRI Scan/Reports
☐	☐	Other	☐	☐	Cardiac Studies
			☐	☐	Lab Results

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus. It may also include information about behavioral health or mental health services for treatment for alcohol and drug abuse.

Re disclosure: I understand that any disclosure of information carries with it the potential for re disclosure and that the information may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And, I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.
(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked this authorization will expire on the following date: _____/______/_____

I give my consent to Emas Spine and Brain Specialists and all its agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of Emas Spine and Brain Specialists of if Emas Spine and Brain Specialists or its agents suspects illegal activity. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by Emas Spine and Brain Specialists without order of clerk or court.

____ _____/______/_____ ____

Signature of Patient or Legal Representative Date Relationship to Patient