NuVasive Clinical Services

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I REQUEST A COPY OF MY HEALTH INFORMATION OR AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION PERTAINING TO SERVICES OR TREATMENT RENDERED, FOR:

*Patient Name: _____ Also known as: _____

*Date of Birth: _____/_____/_____ *Telephone: (_____) _____

*Date of Service: _____ / _____/ _____ *Name of Treatment Facility: _____

*State that the Treatment Facility is located (e.g. California): _____

HEALTH INFORMATION TO BE RELEASED:

☐ Billing Statement ☐ Monitoring Report

☐ Designated Record Set

I WOULD LIKE THE HEALTH INFORMATION:

☐ Mailed ☐ E-mailed**

** If sent via email, the information will be encrypted and will require a self-registration process in order to review the contents. NuVasive Clinical Services is not responsible if the email address you designated below is inaccurate.

***RELEASE RECORDS TO:** _____

_____

Mailing Address City State Zip Code

(_____)_____ _____

Phone Number Secured Email

PURPOSE/ USE OF THE DISCLOSURE:

☐ Continued Care ☐ Legal ☐ Personal ☐ Other: _____

NAME/SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

*PRINT NAME: _____

*SIGNATURE: _____ DATE: _____

If signed by other than patient, indicate authorization:

☐ DPOA ☐ DPR ☐ Parent/ Legal Guardian ☐ Other: _____

NuVasive Clinical Services

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please read carefully and complete the reverse side of this form.

All sections of this Authorization Form must be completely filled out before NuVasive Clinical Services is permitted to disclose your health information.

EXPLANATION: This form authorizes the disclosure of health information in the manner described below and is voluntary. NuVasive Clinical Services (NCS) cannot condition services on whether or not you sign this authorization except under limited circumstances such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as worker's compensation). In these circumstances, NCS may refuse services unless you provide an authorization for the disclosure of your information. Please be aware that once your information is disclosed to a party other than NCS, NCS will no longer be able to protect the confidentiality of your information, and the recipients of your information may not be legally required to protect your information.

TYPES OF ACCEPTABLE AUTHORIZATIONS: Legal authorization is required for someone other than the patient to sign this form. These can include: Designated Power of Attorney (DPOA); Designated Personal Representative (DPR); Conservatorship; and/or Parent/ Legal Guardian.

DURATION: I understand this Authorization may be revoked in writing at any time, according to the instructions in the NCS Notice of Privacy Practices, except to the extent that action has been taken in reliance on this Authorization Form. Unless revoked, this Authorization Form is valid for one year.

REQUEST TO INSPECT: I understand that I have a right to inspect my record within the designated record set. The request to inspect must be done in writing, and the record will be available during normal business hours within 5 working days after the request is received.

CHARGES: There is no charge for records to be sent directly to a patient, an authorized representative, or another health care provider. Records released to a legal attorney or via a subpoena will incur a fee of $15 dollars to cover clerical costs and postage.

ADDITIONAL COPY: I further understand that I have the right to receive a copy of this authorization upon my request.