

**WEST AUGUSTA SPINE SPECIALISTS**

1226 West Wheeler Parkway  
Augusta, Georgia 30909  
(706) 922-4450

**AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.** I understand that this authorization is voluntary. I understand that the organization authorized to receive the information is not a health plan or a health care provider, and that the information released may be redisclosed and may no longer be protected by federal privacy regulations.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Person/organization authorized to release information: **West Augusta Spine Specialists**  
Person/organization authorized to receive information: **Another Physician, Patient's Ins. Co.**

Specific description of information (including dates): **Attending Physician's Office Notes**

The patient or the patient's legal representative must read and initial the following statements:

1. I understand that this authorization will expire: **1-YEAR** Initials: \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying West Augusta Spine Specialists in writing. If I do choose to revoke this authorization, it will not have an effect on any actions taken before West Augusta Spine Specialists received the revocation. Initials: \_\_\_\_\_ **Patient, Insurance Company or referral to another Physician**

To be completed by West Augusta Spine Specialists:

1. The purpose of the use or disclosure is: **Continued Patient Care**
2. The information will be used in the following manner: **Patient, Insurance Company or referral to another Physician.**

**NOTICE TO PATIENT:** The patient or the patient's legal representative may inspect and/or copy the protected health information to be disclosed in accordance with West Augusta Spine Specialists access policies. West Augusta Spine Specialists does not limit its right to make use of or disclosure of your information that is required by law or permitted to avoid a serious threat to the health or safety to the public.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient's Legal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient's Legal Representative Date \_\_\_\_\_

Relationship: \_\_\_\_\_

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. WEST AUGUSTA SPINE SPECIALISTS WILL NOT CONDITION TREATMENT OR PAYMENT ON THE PROVISIONS OF THIS AUTHORIZATION.**

# WEST AUGUSTA SPINE SPECIALISTS

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## Acknowledgement of Receipt Of Notice of Privacy Practices

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Patient Name & Address: \_\_\_\_\_

\_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

\_\_\_\_\_

Signature

Date

\_\_\_\_\_

### For Office Use Only

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We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

Prepared By: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_