MIDESSA
NEUROSURGERY & COMPLEX SPINE
Texas neurosurgery and spine destination

8050 E. HWY 191
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Odessa Texas 79765

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(432) 214-2400
midessaneurosurgery.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION.

Patient Information

Patient's Last name | Patient's First name | Middle Initial | Preferred name

DOB | Phone number | Social Security Number

Address | City | State | Zip Code

I authorize Midessa Neurosurgery & Complex Spine to release my protected health information to:

Name

Address | City | State | Zip Code

Phone number | Fax number

- ◯ Records to be mailed
- ◯ Secure E-Mail through the Patient Portal E-Mail address: _____
- ◯ Records to be picked up by: _____ Date of pickup: _____

Information to be released

Provide information in my medical records for date(s) of service: From: _____ To: _____

- ☐ All medical records
- ☐ Consultation Reports
- ☐ Office Visit Notes
- ☐ History & Physical
- ☐ X-Rays/Imaging Reports
- ☐ Laboratory Tests
- ☐ Billing Records
- ☐ Other/Specific Information: _____

If you fail to specify time period above, only information in the last 24 months will be released.

Purpose of the Release

- ☐ Continued Patient Care
- ☐ Worker's Comp
- ☐ Personal Use
- ☐ Insurance Coverage or Payment for Care
- ☐ Attorney's Office
- ☐ Other (please specify): _____

Patient Authorization

☐ I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for the records to be released.

EXCLUDE the following information from the records release:

- ☐ Drug/Alcohol abuse treatment and/or diagnosis
- ☐ HIV/AIDS testing, treatment and/or diagnosis
- ☐ Sexually Transmitted Diseases treatment and/or diagnosis
- ☐ Mental Illness or Psychiatric treatmentand/or diagnosis

Notice

Midessa Neurosurgery & Complex Spine and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

My Rights

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time, with some exceptions, provided that I do so in writing and submit the request to Medical Records. The revocation will take effect when Midessa Neurosurgery & Complex Spine receives it, except to the extent that Midessa Neurosurgery & Complex Spine or others have already relied on it. For more detailed information on when I can and cannot revoke this Authorization, I can read the Midessa Neurosurgery & Complex Spine's Notice of Privacy Practices. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I am entitled to receive a copy of this Authorization.

Expiration of Authorization

Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire automatically six (6) months from the date signed. I understand the matters discussed on this form. I release Midessa Neurosurgery & Complex Spine its employees, agents, officers, directors and medical staff members from any legal responsibility for the disclosure of the above information to the extent indicated and authorized herein. There may be a reasonable charge for copies of your medical records.

	Name
Signature of Patient / Representative	Date

If signed by legally authorized representative; state your relationship to the patient and your authority to act for patient (please attach evidence, if appropriate). Please mail, fax, e-mail as an attachment (please note email is not a secure method for transmitting sensitive information) or deliver this form in person to:

Attention Medical Records
Midessa Neurosurgery and Complex Spine
8050 E. Hwy 191, suite 250
Odessa, Texas 79765
medicalrecord@midessaneurosurgery.com

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