

# AUGUSTA BACK



## NEUROSCIENCE

### PATIENT HISTORY SHEET

*To be completed by patient:*

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

Referring doctor: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Past Medical History - patient

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History - Patient

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Treating Physicians: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Significant Family Medical History:

Parents: \_\_\_\_\_  
\_\_\_\_\_

Siblings: \_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

*To be completed by nurse and physician*

Social history: Smoke? \_\_\_\_\_ Use Alcohol? \_\_\_\_\_ Married? \_\_\_\_\_

Occupation: \_\_\_\_\_

Circle those systems with problem and explain on right

Eye/ear/nose/throat: \_\_\_\_\_

Lungs: \_\_\_\_\_

Heart: \_\_\_\_\_

GU (Kidney/bladder): \_\_\_\_\_

GI (Stomach/intestines): \_\_\_\_\_

Muscles: \_\_\_\_\_

Skin: \_\_\_\_\_

Psychiatric: \_\_\_\_\_

Neurological: \_\_\_\_\_

Endocrinologic: \_\_\_\_\_

Hematologic: \_\_\_\_\_

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

Signature of patient: \_\_\_\_\_

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

Signature of doctor: \_\_\_\_\_



# AUGUSTA BACK NEUROSCIENCE

840 Stevens Creek Road • Augusta, GA 30907  
(706) 722-6957

## NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to Medical Records. Your request must state a time period, which may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Augusta Back. To request an amendment, your request must be made in writing and submitted to Medical Records. In addition, you must provide a reason that supports your request.
  - We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for Augusta Back;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.
- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Medical Records. If you request a copy of the information, we are entitled to charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Augusta Back will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of the notice at our website, [www.augustaback.com](http://www.augustaback.com). To obtain a paper copy of this notice contact Medical Records.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing in Medical Records. We will not ask you the reason for the request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Medical Records. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

#### CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in Augusta Back. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you visit Augusta Back for treatment or health care services, we will offer you a copy of the current notice in effect.

#### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Augusta Back or with the Secretary of the Department of Health and Human Services. To file a complaint with Augusta Back, contact us at 706-722-6957. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

#### OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

If you have any questions about this notice, please contact this organization's Privacy Officer.

Effective Date: \_\_\_\_\_

# AUGUSTA BACK NEUROSCIENCE

840 Stevens Creek Road • Augusta, GA 30907  
(706) 722-6957

## POLICY 3.3

### AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
\_\_\_\_\_

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure:

\_\_\_\_\_  
\_\_\_\_\_

Information that *may not be used or disclosed*:

\_\_\_\_\_  
\_\_\_\_\_

The name or other specific identification of the person(s), or class of persons, *authorized to make the requested use or disclosure*:

\_\_\_\_\_  
\_\_\_\_\_

The name or other specific identification of the person(s), or class of persons, to whom Augusta Back *may make the requested use or disclosure*:

\_\_\_\_\_  
\_\_\_\_\_

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

\_\_\_\_\_  
\_\_\_\_\_

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

\_\_\_\_\_  
Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

\_\_\_\_\_

# AUGUSTA BACK NEUROSCIENCE

840 Stevens Creek Road • Augusta, GA 30907  
(706) 722-6957

EFFECTIVE DATE \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES [SHORT FORM]

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.**

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.** The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at Augusta Back may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Augusta Back or the hospital. For example, we may disclose medical information about you to people outside Augusta Back who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Augusta Back and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Augusta Back personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. **WHO WILL FOLLOW THIS NOTICE.** This notice describes Augusta Back's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Augusta Back personnel.

**POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION.** We create a record of the care and services you receive at Augusta Back. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Augusta Back, whether made by Augusta Back personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

### **NOTICE OF INDIVIDUAL RIGHTS**

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**Right to Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, Augusta Back. To request an amendment, your request must be made in writing and submitted to Medical Records and you must provide a reason that supports your request. We may deny your request for an amendment. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restriction, you must make your request in writing to Medical Records.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to Medical Records.

**CHANGES TO THIS NOTICE.** We reserve the right to change this notice. We will post a copy of the current notice in Augusta Back's waiting room. **COMPLAINTS.** If you believe your privacy rights have been violated, you may file a complaint with Augusta Back or with the Secretary of the Department of Health and Human Services. To file a complaint with Augusta Back, **contact us at 706-722-6957.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** **OTHER USES OF MEDICAL INFORMATION.** Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact Medical Records.

**I acknowledge by signing below that I have received the Notice of Privacy Centers and Notice of Individual Rights.**

\_\_\_\_\_  
Patient or Patient's Personal Representative

\_\_\_\_\_  
Date

Date: \_\_\_\_\_ Patient Name \_\_\_\_\_

### Review of Systems

Are you currently, or have you had, problems with:

	<i>Circle One</i>			<i>Circle One</i>	
<b>Constitutional</b>			<b>Respiratory</b>		
Weight gains	Yes	No	Asthma	Yes	No
Weight loss	Yes	No	Coughing up blood	Yes	No
Night sweats	Yes	No	TB	Yes	No
Insomnia	Yes	No	Pneumonia	Yes	No
			Trouble breathing	Yes	No
<b>Eyes</b>			Snoring	Yes	No
Double vision	Yes	No			
Visual loss	Yes	No	<b>Gastrointestinal</b>		
			Indigestion or		
<b>Ear, Nose, Throat and Mouth</b>			Heartburn	Yes	No
Hearing loss	Yes	No	Ulcer	Yes	No
Noise/ringing in ears	Yes	No	Hepatitis	Yes	No
Nasal congestion	Yes	No	Jaundice	Yes	No
Nasal drainage	Yes	No	Blood in stool	Yes	No
Sore throat	Yes	No	Black, tarry stools	Yes	No
Trouble swallowing	Yes	No			
Hoarseness	Yes	No	<b>Genitourinary</b>		
			Bladder trouble	Yes	No
<b>Cardiovascular</b>			Prostate disease	Yes	No
Chest pain or angina	Yes	No	Kidney disease	Yes	No
Heart trouble	Yes	No			
Rheumatic fever	Yes	No	<b>Musculoskeletal</b>		
Heart murmur	Yes	No	Arthritis	Yes	No
High blood pressure	Yes	No			
			<b>Endocrine</b>		
<b>Neurological</b>			Diabetes	Yes	No
Numbness	Yes	No	Thyroid disease	Yes	No
Weakness	Yes	No			
Stroke	Yes	No	<b>Hematologic</b>		
Headache	Yes	No	Bleeding disorder	Yes	No
			Easy bleeding	Yes	No
<b>Psychiatric</b>					
Depression	Yes	No			
<b>Allergic/Immunologic</b>					
Sneezing	Yes	No			
Itchy eyes/nose	Yes	No			
Itchy throat	Yes	No			
Skin rash	Yes	No			
HIV	Yes	No			

Circle your pain level on a scale of 1 to 10, with 1 being no pain at all, and 10 being extreme pain.

1	2	3	4	5	6	7	8	9	10
(no pain)					(extreme pain)				

The above information is accurate to the best of my knowledge.

I have reviewed the above information with the patient, \_\_\_\_\_  
*Patient Signature* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

Other histories, medications, allergies, and the review of systems have been reviewed with the patient and are documented in the chart. The patient has been instructed to follow up with their primary care provider for all issues noted in the system review not related to their complaint for the office visit today.

DOCTOR:

ABRAMSON  GUITTON   
 BAKER  OETTING   
 CABLE  SHAVER   
 STEWART

REFERRED BY \_\_\_\_\_

NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

IF YOU USE A POST OFFICE BOX PLEASE LIST HERE \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ RACE B W O SEX M F Married Divorced Widowed Single

EMPLOYER NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_ SPOUSE/PARENT SOC. SEC. # \_\_\_\_\_ SPOUSE DATE OF BIRTH \_\_\_\_\_

IN AN EMERGENCY, PLEASE NOTIFY (OTHER THAN SPOUSE)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

PAST MEDICAL PROBLEMS: \_\_\_\_\_

COMPLAINT TODAY: \_\_\_\_\_

DATE OF FIRST SYMPTOMS: \_\_\_\_\_ AUTO ACCIDENT  W/C  OTHER

## INSURANCE INFORMATION

**PLEASE NOTE - PRE-CERTIFICATION IS THE PATIENT'S RESPONSIBILITY**

PRIMARY INSURANCE:		IS PRE-CERTIFICATION REQUIRED? <u>YES</u> <u>NO</u>	
NAME OF INSURANCE _____	NAME OF INSURED: _____		
POLICY # _____	INSURED'S DATE OF BIRTH: _____		
GROUP# _____	RELATIONSHIP TO PATIENT: _____		
INSURED'S _____	MAIL CLAIM TO: _____		
EMPLOYER NAME _____	ADDRESS: _____		
SECONDARY INSURANCE:		IS PRE-CERTIFICATION REQUIRED? <u>YES</u> <u>NO</u>	
NAME OF INSURANCE _____	NAME OF INSURED: _____		
POLICY # _____	INSURED'S DATE OF BIRTH: _____		
GROUP# _____	RELATIONSHIP TO PATIENT: _____		
INSURED'S _____	MAIL CLAIM TO: _____		
EMPLOYER NAME _____	ADDRESS: _____		
WORKERS' COMPENSATION INFORMATION			
W/C CARRIER _____	DATE OF INJURY _____		
W/C ADDRESS _____	W/C PHONE _____		
DESCRIBE INJURY _____			

### CONSENT FOR TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

CONSENT FOR EXAMINATION/TREATMENT: I HEREBY AUTHORIZE AND CONSENT TO SUCH EXAMINATIONS AND TREATMENTS BY AUGUSTA BACK/NEUROSCIENCE, AS MAY BE ORDERED BY THE DOCTOR IN CHARGE OF THIS CASE.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

RELEASE OF MEDICAL INFORMATION: I HEREBY AUTHORIZE AUGUSTA BACK/NEUROSCIENCE TO RELEASE MEDICAL INFORMATION AND OTHER INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT TO MY INSURANCE COMPANY, CLAIMS REPRESENTATIVE, ADJUSTOR, OTHER PHYSICIANS AND/OR ATTORNEY.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

### ASSIGNMENT OF MEDICAL/HEALTH BENEFITS

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDENTS. I AGREE TO PAY ALL MEDICAL SERVICE CHARGES NOT COVERED BY INSURANCE.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**AUGUSTA BACK**  
**Financial Policy**

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policy as an essential element of your care and treatment. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. If you have any questions, please feel free to call and discuss them with our billing and insurance department at 706-722-6957.

\_\_\_\_\_ **All co-pays and/or deductibles are due at the time of service or the appointment will be rescheduled. Self-pay balances are to be paid in full at check-in or with prior approval put on a monthly payment plan, not to exceed 6 months.** All balances over \$500 will be given a 15% discount if the amount is paid in full. We require that all deductibles be paid in full *prior* to any surgery or procedure. For your convenience, we accept cash, personal checks, Visa, MasterCard, and Discover. As a courtesy, we will accept personal checks as payment. Returned checks and balances older than 90 days will be subject to collection fees and finance charges.

\_\_\_\_\_ We ask that you give at least 24 hours notice should you need to cancel an appointment. **Appointments that are not cancelled prior to 24 hours will be billed to you directly. Failing to keep your appointment will result in a \$25.00 charge for office visits and \$75.00 for procedures.** This fee is not covered by your insurance and payment will be expected before another appointment can be scheduled.

\_\_\_\_\_ We file your insurance as a courtesy to you. However, it is **your responsibility** to ensure that your insurance pays correctly and in a timely fashion. All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your physician, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. It is also your responsibility to know what services (radiology, therapies, treatments, hospitalization, labs, etc.) are covered by your insurance and to ensure all required referrals/pre-authorizations have been obtained. It is impossible for our staff to be aware of the terms of your insurance.

\_\_\_\_\_ It is also **your responsibility** to ensure that your insurance is effective at time of service. If your insurance is not active, you are responsible for **all charges in full at time of service**. Unfortunately, we are unable to back file claims for policies inactive at time of service.

\_\_\_\_\_ **All accounts are payable in full (either by your insurance company or you) within 90 days.** Please contact our billing department if you have extenuating circumstances. Please be aware that we use the services of an outside collection agency for past due accounts. In the event that your account is turned over to collections, you may be responsible for all reasonable collection and court costs.

\_\_\_\_\_ Unpaid balances are billed monthly. Please call if you have a question about your bill. Most problems can be settled quickly and easily. We strive to remain flexible and understanding of individual circumstances and we will do our best to help.

\_\_\_\_\_ Failure to make agreed upon payments when due or within 5 days thereafter will result in the entire balance becoming immediately due and payable.

\_\_\_\_\_ It is impossible for us to know all employer insurance changes within the CSRA. Most insurance companies have filing deadlines, therefore, it is **your responsibility** to provide us with a copy of your most current insurance card **at the time of each visit** in order for us to file each claim in a timely manner. Failure to do so could result in increased out of pocket expenses for the patient.

**I have read and understand the financial policy of Augusta Back Neuroscience and agree to be bound by its terms.**

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**Signature of Parent/Responsible Party**

**Date**

---

**Printed Name**

Updated 07/17/2011

# AUGUSTA BACK NEUROSCIENCE

840 STEVENS CREEK ROAD • AUGUSTA, GA 30907  
(706) 722-6957

## AUTHORIZATION FOR RELEASE OF INFORMATION

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

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Telephone \_\_\_\_\_

I authorize the release of medical information as indicated below:

FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

I would like to pick up my records: please call me at \_\_\_\_\_  I would like the records mailed (please indicate address above)

**What to Release: Please choose the records you would like released:**

- |  |  |
|--|--|
| <input type="checkbox"/> Outpatient notes    | <input type="checkbox"/> Laboratory reports  |
| <input type="checkbox"/> X-Ray report(s)     | <input type="checkbox"/> X-ray Film(s)       |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Immunization record |
| <input type="checkbox"/> Other Specify _____ | <input type="checkbox"/> All medical records |

**NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:**

- |  |   |
|--|---|
| The diagnosis or treatment of AIDS, including results of HIV tests           | <input type="checkbox"/> Yes <input type="checkbox"/> No/NA |
| The diagnosis or treatment of drug and/or alcohol abuse                      | <input type="checkbox"/> Yes <input type="checkbox"/> No/NA |
| The treatment and/or consultation for mental health or psychiatric disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No/NA |

**Purpose of the release: Please indicate the reason for this release**

- |   |   |
|---|---|
| <input type="checkbox"/> For another doctor             | <input type="checkbox"/> To obtain disability     |
| <input type="checkbox"/> Use in a lawsuit               | <input type="checkbox"/> Worker's care            |
| <input type="checkbox"/> Follow-up related to an injury | <input type="checkbox"/> Armed forces requirement |
| <input type="checkbox"/> Personal use                   | <input type="checkbox"/> Other _____              |

**Expiration date: This authorization will expire in sixty days unless otherwise indicated below:**

Please change the expiration date to last for \_\_\_\_\_ days.

I understand this Authorization can be revoked at any time according to the Augusta Back/Neuroscience privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Augusta Back/Neuroscience and may potentially be re-disclosed by the party who received these records. Augusta Back/Neuroscience, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

\_\_\_\_\_  
Signature of the patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of legal representative and relationship to patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

Form 10ARI