SpineCare Of NY
The Hospital For Special Surgery

THE OFFICES OF
FRANK P. CAMMISA, JR., M.D., F.A.C.S.
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ALEXANDER P. HUGHES, M.D.

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name: _____ Social Security Number: _____

Persons/Organizations authorized to use/disclose or receive my information:
_____
_____
_____

Specific description of the information to be used to disclosed (including date(s)} :
_____

_____

Description of each purpose of the use or disclosure of my health information:

At the request of the patient.
I understand that this authorization will expire on; _____ Initials _____

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form, Initials _____

I understand that I will get a copy of this form after I sign it. Initials_____

I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on the actions the Practice has already taken in reliance on this authorization. Initials_____

_____ _____
Signature of patient Date

If this authorization is signed by a patient's representative, please complete the following;

_____
Printed name of patient's representative

_____
Relationship to the patient