BAYOU
PAIN & SPINE
ARTEMUS FLAGG II, MD, MPH

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient: _____ SS# _____ Date of Birth: _____

I hereby ***authorize*** Bayou Pain & Spine's staff to release verbal communication for friends/family to

Name and Relationship to Patient, and Phone#/Cell Phone#

_____

_____

Right to Revoke I understand that I have the right to revoke this Authorization in writing at any time subject to the exceptions stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. In addition, I must sign my request and then mail or deliver my request to the **Bayou Pain & Spine Medical Record Department.**

Exceptions to the Right of Revocation: I understand that my written revocation will not affect the ability of Pontchartrain Cancer Center to continue to use or disclose my health information to the extent that it has already acted in reliance on this Authorization.

Potential for Re-disclosure: Your health information disclosed according to this authorization will no longer be protected by the federal privacy law (known as "HIPAA"), and the recipient of the information may potentially re-disclose it.

Authorization Approval and Receipt Acknowledgement:

I hereby authorize the use or disclosure of the health information described in this authorization and acknowledge receiving a signed copy of this authorization.

I understand that if anyone who receives my health information is not a health care provider or a health plan, my health information may not be protected by federal privacy laws if my health information is re-disclosed by that recipient person.

Name: (Print) _____ Date: _____

Signature: _____

Please check: _____ Patient _____ Parent _____ Guardian