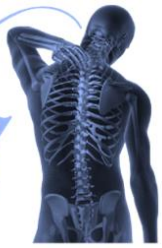
Alaska
Spine and Pain Center
DR. CALEB J. CRAIG



Patient Record of Disclosure

In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be mad by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

DO NOT contact me in the following manner (***Skip, if ok to contact you***):

( ) Home Telephone ( ) Written Communication ( ) Work Telephone ( ) Cellular Phone

Information to be sent, used or disclosed may include but not limited to billing information, treatment information, thank you letters, birthday cards, notices, newsletters, etc…

Persons to Whom Information May Be Disclosed (Please list):

Family Members: _____
Insurance Company (for billing purposes): _____
Attorney, Case Worker, Others: _____

Expiration Date of Authorization
This authorization is effective indefinitely unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Arctic Spine & Pain Center.

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again y the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided in your file completed properly, will constitute an adequate record.

Please Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Print Name of Patient: _____

Signature of Patient: _____ **Date:** _____

Print Name of Representative: _____

Signature of Representative: _____ **Date:** _____