

**YOUR PERSONAL HEALTH INFORMATION**

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Personal Phone # \_\_\_\_\_ Date of Birth (M/D/Y) \_\_\_\_\_

Please check off all situations below where you would grant the individuals listed access to your PHI:

- \_\_\_\_\_ Confirmation of appointment details (including surgical scheduling)
- \_\_\_\_\_ Diagnostic testing results
- \_\_\_\_\_ Details of surgery and outcome
- \_\_\_\_\_ Picking up medical records
- \_\_\_\_\_ Permission to leave a message on answering machine

Please list the individuals for whom you authorize access to your PHI:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Acknowledgment:

By submitting this form, I hereby permit North Jersey Spine Group to disclose my PHI to the individuals listed above. Authorized individuals must present identification as proof that they are who they claim to be.

Signature: \_\_\_\_\_ Date of Authorization: \_\_\_\_\_