## DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to office policy, test results or release of medical information will be provided to the patient only. Please specify below to whom information may be released to other than the patient.

- ☐ Patient only
- ☐ Spouse - Name: ______________________________________________
- ☐ Children - Name(s): ___________________________________________
- ☐ Other (state relationship) - Name: ________________________________
- ☐ Doctors Office: _______________________________________________

May we leave messages at your:

- ☐ Home Answering Machine # ____________________________________
- ☐ Cell Phone # _________________________________________________
- ☐ Work Voice Mail # _____________________________________________
- ☐ Email Address: _______________________________________________
- ☐ Other (please specify) # ________________________________________

I have received a copy of Chattanooga Neurosurgery & Spine Privacy Notice explaining the uses and disclosures of my health information:

☐ **Yes** ☐ **No** **Patient Initials**: ____________

## NOTICE REGARDING PRESCRIPTION REFILLS

Please note that the patient must call in requests for refills of prescription pain medication personally. Requests **must** be made during normal business hours.

**Please sign your name to verify permission for all information above.**

Patient Signature: ___________________________________ Date: ________________

Revised 3-25-14