AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name____DOB________________________

Home address____

Patient phone number____

I hereby authorize Pain Management Partners to make uses and disclosures of my protected health information (information about me in my medical records and/or financial records as indicated below:

Description of information to be disclosed (please check all that apply):

□ Most recent visit note □ Entire chart □ Test results

□ Consult report □ Imaging/EKG □ Procedure notes

□ Other____

HIV and mental health information contained within the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do NOT release the following: □ Drug and Alcohol □ HIV □ Mental health

Reason for requested use or disclosure:____

Who are we sending the record to? □ Patient □ Physician □ other

Please indicate how you would like the records sent: □ Fax □ Email □ Mail

Please provide the above information: Fax #__________________________________Attention________________

Email address____

Address____

____

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- My decision to revoke this authorization does not apply to any release of my records that may have taken place prior to the date of the revocation if the practice has already taken action.
- The practice will not condition treatment, payment, enrollment or eligibility based on my signing of this authorization.
- I am entitled to a copy of this authorization.
- I am not required to sign this authorization to receive treatment.
- This authorization to release information is effective for a period of one year from the date of signature, unless otherwise specified here. This authorization is effective until ________________________.

____

Patient or patient representative signature Date

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Printed name of patient or patient representative If signed by patient representative, relationship to patient