PAIN CARE CENTERS
Treatment Options Close to Home

Authorization to Release Protected Health Information

I, the undersigned, authorize Pain Care Center, its healthcare providers and staff, to release or receive my health information as noted below:

PATIENT INFORMATION

Full Name: _____ Other Names Used:_____
Date of Birth: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone:_____

Release Information: ⇚ To ⇚ From *Section must be filled out completely for request to be processed.*
Name / Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax:_____

Purpose of Request: ⇚ Personal ⇚ Treatment/Continued Care ⇚ Legal ⇚ Insurance ⇚ Disability
Transfer/Reason: _____ Other:_____

Please Forward Records Via: ⇚ Mail ⇚ Fax (Physician's Off Only) ⇚ Pick Up

Information to be Released:
⇚ Please provide _____ year(s) abstract of my records (includes most recent notes, labs and diagnostic testing)
⇚ Please provide my entire record
⇚ Other: _____

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information. **_____ (Initials of Patient or Legal Representative)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form.
6. I can request a copy of this form after I sign and date it.
7. This release will expire on the date of the earliest of the following events: one year from the signature date, upon a minor's age of majority and/or upon termination of enrollment in the health plan.

Patient's Signature: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

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