CENTRAL STATES PAIN CLINIC℠
INNOVATIVE PERSONAL CARE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Central States Pain Clinic. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the organization.

PATIENT IDENTIFICATION:	Name:_____ Date of Birth:_____ Last 4 digits of SS#:_____ Any previous names under which records may be kept:_____ Telephone number (if we have questions):_____
PROVIDER: (Who is to disclose the information?)	Entity (please specify):_____ Street Address:_____ City, State, Zip:_____ Phone:_____ Fax:_____
RECIPIENT: (Who is to receive the information?)	Name:_____ Street Address:_____ City, State, Zip:_____ Phone:_____ Fax:_____
PURPOSE OF RELEASE: (Check all that apply)	☐ At request of the patient (or legal representative) ☐ Discussion/coordination of care with family members involved with patient's care ☐ Transferring medical care to another health care provider ☐ For claims procession purposes (third party liability claims) ☐ Other (please specify):_____
INFORMATION: (What information should be released?) (Check all that apply)	☐ Records dating from:_____ to:_____ ☐ All dates ☐ Radiology/Imaging Reports ☐ Medical Billing ☐ Other (please list specific records):_____ _____
SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR REDERAL LAW	I specifically authorize the release of information relating to: (Check all that apply) ☐ Mental Health ☐ HIV-related information (including AIDS and related testing) ☐ Substance abuse treatment (Alcohol/Drugs)

I understand my healthcare and payment for my healthcare will not be affected by this authorization.

Signature of patient or legal representative:_____Date:_____

Relationship to patient if signed by legal representative:_____

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