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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