ADVANCED PAIN MEDICINE ASSOCIATES
Providing Hope for Pain Sufferers
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AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

Patient Name :_____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ SSN: _____

I **request that my protected health information (PHI) from _____be disclosed to:**
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip:_____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s): ___ Imaging Reports ___ Office Notes ___ Lab Reports

___ Billing/Accounting Information ___Other:_____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	□ Yes □ No Dates: _____
HIV Testing and Results	□ Yes □ No Dates: _____
Mental Health	□ Yes □ No Dates: _____
Psychotherapy Records	□ Yes □ No Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____

Purpose for requesting information: ___Legal ___Insurance ___Personal ___Continuation of Care ___Other *(please specify on line below):*

_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the HIPAA Compliance Officer at Advanced Pain Medicine Associates. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire *one (1) year* from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- Advanced Pain Medicine Associates is not responsible for the completeness, legibility or exclusion of information caused by the copying and/or re-disclosure of any medical records from another institution.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

{42 C.F.R.Part2: Prohibition of Redisclosure: The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient}.