Authorization for Disclosure of Protected Health Information

ADVANCED PAIN MANAGEMENT

Date Information Desired by:	Patient Name: _____ Date of Birth: _____
	Address (including City/State/Zip): _____
	Phone Number: _____
	Maiden/Previous Names/Nicknames: _____

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Release Information From:

Provider/Facility Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Release Information To:

Name/Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax # *(for provider use only):* _____

Purpose of Release:

☐ Continuing Care ☐ Personal ☐ Transfer of Care ☐ Disability Determination
☐ Legal ☐ Work Comp ☐ Insurance ☐ Other:_____

Information to be Released:

Release Method: ☐ Mail ☐ Fax ☐ Pick-Up Location: _____

Service Dates: From:_____ To:_____

☐ Entire Medical Record ☐ Laboratory Reports ☐ Other (Please specify):_____
☐ Operative/Procedure Notes ☐ Radiology Reports _____
☐ Office Visit Notes ☐ Billing Statements _____

I do not want the following information disclosed (as defined by applicable state and federal laws) :

☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AIDS ☐ Alcohol/Drug Abuse ☐ Genetic Information

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here:_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Refuse to Sign This Authorization. I understand that I have the right to refuse to sign this Authorization and APM will not condition treatment or payment upon my signing of this Authorization.

Right to Revoke Authorization. I understand that I have the right to revoke this Authorization, except to the extent that APM has already disclosed my medical information in reliance of this Authorization. I understand that my revocation is effective only if it is in writing. To revoke my Authorization, I understand that I must send a written request for revocation to APM's corporate medical records staff, Attn: Medical Records Supervisor.

Re-disclosure of Information by Recipient. I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person(s)/organization(s) receiving my medical information and no longer protected by applicable privacy laws.

Right to Receive a Copy of This Authorization and My Medical Information. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I also have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization.

By signing this form, I am authorizing Advanced Pain Management and its affiliates and subsidiaries ("APM") to disclose my medical information as described in this Authorization.

Signature *(required)*:	**Date Signed** *(required)*:
Printed Name of Person Signing (If not patient):	

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Activated Power of Attorney ☐ Next of Kin