AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize ADVANCED INTERVENTIONAL PAIN CONSULTANTS to obtain / release my protected health information as described below from / to:
(Name and address of recipient):____

____For the following purposes: Medical Records for Continuing Care

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying ADVANCED INTERVENTIONAL PAIN CONSULTANTS in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) ADVANCED INTERVENTIONAL PAIN CONSULTANTS agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed

☐ Entire Medical Record ☐ Most Recent 5 Year History ☐ Radiology Reports
☐ Office Chart Notes ☐ History and Physical Exam ☐ Operative Reports
☐ Billing Statements ☐ Emergency and Urgent Care Records
☐ Laboratory Reports ☐ Emergency Room Reports ☐ Other Any Imaging Reports
☐ Consultation ☐ Discharge Summary **ASAP**_____________

In addition, I authorize that this will include health information relating to (check if applicable):
☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Expiration:
This authorization will expire 180 days from the date of signing or **(insert date)** ____________________

Patient Name: ____ **DOB:** ________________________

____ _________________________________
Signature of Patient or Legal Representative **Date**

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
☐ Parent or guardian of emancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

____ _________________________________
Signature of Witness **Date**

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