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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Pain Partners, MD to use, release, disclose or request the protected health information described below:

Family member (name) _____

Self (name) _____

Records Request (if records are needed from another physician)

Name and address of Physician or Practice:

Please send my medical records to Pain Partners, MD, 380 Empire Rd. Suite 200 Lafayette, CO 80026

Purpose of records request: _____

- Recent chart notes MRIs, X-rays Complete record Labs
- Other _____

Sensitive Information and Redisclosure: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. Any disclosure of information carries with it the potential for redisclosure and that information may not be protected by federal and confidentiality rules.

Right to revoke and Other Rights: I understand that I have the right to revoke this authorization at any time, in writing, and that revocation will not apply to information already released based on this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, I may be denied participation in any research studies if my authorization is not obtained. I understand that I may inspect or obtain a copy of information to be disclosed, if applicable.

Expiration: Unless otherwise revoked, this authorization will expire upon the execution of a newly signed and dated document.

Patient or Representative Signature: _____ Date: _____

Relationship of Representative: _____