



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: Last First Middle Date of Birth:

Patient's Address: City State Zip

Home Phone: Business Phone Cell Phone: E-Mail:

PERSON OR ENTITY TO RELEASE INFORMATION

- Complete Pain Care, LLC
Other
Name:
Address:

PERSON OR ENTITY TO RECEIVE INFORMATION

- Complete Pain Care, LLC
Other
Name:
Address:

SPECIFIC INFORMATION TO BE DISCLOSED (check as needed)

- Complete Medical Record Office Notes Lab Reports Procedure Reports
Surgery Records Billing Records Other (Specify)

FEE FOR COPIES

- \$15 per request; \$0.50 per page for the first 100 pages; and \$0.25 per page for every page over 100; and,
Actual cost for postage; and,
Actual cost for the copying of x-rays and other records not reproducible by ordinary photocopying; and,
Clerical fees that may not exceed \$25.00 an hour.
NO CHARGE for records provided to Medical Providers

DATES OF SERVICE:

PURPOSE: Changing Physicians Personal Copy to Patient Attorney Insurance
Workman's Compensation Other

This authorization will expire on . (If no date specified, this authorization shall expire 1 year after date signed.)

CHECK AND INITIAL BELOW:

I DO, I DO NOT authorize the release of information pertaining to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, and all medical records and clinical information relating thereto.

(Initials of individual giving authorization)

I DO, I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for mental health or psychiatric conditions.

(Initials of individual giving authorization)

I DO, I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for drug or alcohol abuse, drug-related and/or alcohol-related treatment.

(Initials of individual giving authorization)

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use of disclosure of the information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and/or information.

Signature of Patient or Patient's Representative

Witness

Relationship to Patient
(If applicable, attach document of guardianship or Power of Attorney)

Date