Authorization for Use and Disclosure of Protected Health Information (PHI)

Record Request Form

Patients Last Name	First Name	Da	ite Of Birth	Last 4 #'s of Social Security		
Address	City	Sto	ate	Zip Code		
Facility/Doctors authorized to requ						
Innovative Pain Care Center 9920 W. Cheyenne Ave #110 Las Vegas, Nevada 89129						
Office (702) 316-2281 Fax (702) 316-2272						
Medical records authorized to be released from: (this section must be filled out completely)						
Cadilla as Dadas Nassa	Office Dhous Number	F	x Number			
Facility or Doctor Name	Doctor Name Office Phone Number		x Number	***************************************		
Address	City	Sto	nte	Zip Code		
Address	Torry			Lip Code		
This authorization shall expire on t	he following date or ev	ent:				
If I fail to specify an expiration date or event			the date			
on which it was signed.						
Purpose of disclosure:	O Insurance Reasons	0	Medical Care			
	O Personal Reasons	0	O Legal Reasons			
	O Other:	and the second s				
Description of Information to be used or disclosed: Starting Date: End Date:						
O All Dill in the medical records	O Canadhatian Danad	0	V Day Task/was			
O All PHI in the medical records	O Consultation Report O Discharge Summary		X-Ray Test/repo			
O History and Physical reports O Progress Notes	O Discharge Summary O Itemized Billing Star		Patient Inform			
Progress Notes	O iterrized billing 5td	ements 0	Patient inform	acion i onti		
The Protected Health Information l	isted below WILL BE r	eleased when in	ncluded in the a	bove		
medical information unless specific	cally indicated otherwi	se.				
Psychiatric/Mental Information	AIDS/HIV/Genetic Inform	nation Ale	cohol/Drug/Substar	nce Abuse Information		
I understand that:				**************************************		
1. I may refuse to sign this authorization and that it is strictly voluntary.						
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless						
stated otherwise.						
3. I understand that I have the right to revoke this authorization at any time in writing and must present						
the written revocation to the provider authorized to release the protected health information.						
I understand if I do revoke this authorization it will not apply to information that has already been						
released to this authorization.						
4. If the requestor or receiver is not a health plan or health care provider, the released information may						
no longer be protected by federal privacy regulations and may be redisclosed.						
5. I understand that I may see and obtain a copy of the information described on this form, for						
a reasonable copy fee, if I ask for it.						
I have read the above and authorized the disclosure of the protected health information as stated:						
Patient Signature		Do	ıte			
				Dete		
Patient Representative Signature		Re	lationship	Date		

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Record Release Form

Patients Last Name	First Name	Date Of Birth	Last 4 #'s of Social Security				
Tations Last Name	, marketine		auto i ii y oi yocidi yoculi iy				
Address	City	State	Zip Code				
A STATE OF THE STA	1	And the second s					
		egas, Nevada 89129					
Medical records to be released to:(this section must be filled out completely)							
medical records to be released to.(t							
Facility or Doctor Name	Office Phone Number	Fax Number					
Address	City	State	Zip Code				
This authorization shall expire on tl	-						
If I fail to specify an expiration date or event	, this authorization will expire (12) mont	ths from the date					
on which it was signed.							
Purpose of disclosure:	O Insurance Reasons	O Medical Care					
	O Personal Reasons	O Legal Reasons					
	O Other:						
Description of Information to be used or disclosed: Starting Date: End Date:							
O All PHI in the medical records	O Consultation Reports	O X-Ray Test/rep	orts				
O History and Physical reports	O Discharge Summary	O Laboratory Rep					
O Progress Notes	O Itemized Billing Statements	O Patient Inform					
_							
The Protected Health Information l		when included in the a	lbove				
medical information unless specifically indicated otherwise.							
Psychiatric/Mental Information	AIDS/HIV/Genetic Information	Alcohol/Drug/Substal	Alcohol/Drug/Substance Abuse Information				
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a reasonable copy fee, if I ask for it.							
a realization copy roop in a control to							
I have read the above and authorized the disclosure of the protected health information as stated:							
	*						
Patient Signature		Date					
Datient Representative Signature		Relationship	Date				