Innovative Pain Care Center

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PainFreeNevada.com

RECORD RELEASE FORM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name (Last) _____ (First) _____

Birth Date _____ Last 4 #'s of Social Security _____

Address _____City _____ State _____ Zip _____

Facility/Doctors authorized to release medical records (PHI)

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 to: *(this section must be filled out completely)*

Facility or Doctor Name _____ Phone _____ Fax _____

Address _____City _____ State _____ Zip _____

This authorization shall expire on the following date or event: _____

If I fail to specify an expiration date or event, this authorization will expire (12) months from the date on which it was signed.

Purpose of disclosure:

☐ Insurance Reasons ☐ Medical Care ☐ Personal Reasons ☐ Legal Reasons ☐ Other: _____

Description of Information to be used or disclosed: Starting Date _____ End Date _____

☐ All PHI in the medical records	☐ Consultation Reports	☐ X-Ray Test Reports
☐ History and Physical reports	☐ Discharge Summary	☐ Laboratory Reports
☐ Progress Notes	☐ Itemized Billing Statements	☐ Patient Information Form

The Protected Health Information listed below WILL BE released when included in the above medical information unless specifically indicated otherwise.

☐ Psychiatric/Mental Information ☐ AIDS/HIV/Genetic Information ☐ Alcohol/Drug/Substance 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 disclosed.
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 **Date**

_____ _____ _____

Parent Representative Signature **Relationship** **Date**