

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT IDENTIFICATION:

Name: _____
 Patient Phone#: (____) _____ Date of Birth _____ S.S.# _____

PROVIDER: (Who is releasing information)

PAIN SOLUTIONS TREATMENT CENTERS

RELEASE RECORDS TO:

(Person or Place records should be sent)

Name: _____
 Address: _____
 Phone#: (____) _____ Apt, Suite or PO#: _____
 Fax#: (____) _____ City, State, and Zip: _____

(RECORDS WILL ONLY BE FAXED TO ANOTHER PHYSICIAN)

A COMPLETE MAILING ADDRESS IS REQUIRED TO PROCESS ALL MEDICAL RECORD REQUEST

DATES OF TREATMENT:

Dates: _____

INFORMATION REQUESTED:

- Ongoing Care Summary-(Courtesy/No charge for patient's when records are sent directly to another physician)
- Progress/Office Notes Lab Reports Radiology Reports (MRI'S) Itemized Statement
- Diagnostic Studies (EKG'S/Cardiac Studies) All-Complete Chart Other _____

PURPOSE OF RELEASE:

- Medical Care Insurance Legal Personal
- Other _____

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

SPECIFIC INFORMATION NOT TO BE DISCLOSED: _____

This form is valid for one year from patient signature date

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that one the above information is disclosed it may be subject to disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Pain Solutions Treatment Centers. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature. I hereby authorize Pain Solutions Treatment Centers and/or ScanTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable. I hereby release Pain Solutions Treatment Centers and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. I authorize that this information may be faxed when applicable.

PATIENT'S SIGNATURE

DATE

PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN

DATE

WITNESS

DATE