PainCARE
Dr. Daniel Bruning & Dr. Kimber Eubanks

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

Records to be disclosed:

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED *(examples: All records, X-Rays only, records for last 12 months)* AND/OR CHECK ALL THAT APPLY:

□ **Office Visit/Procedure Notes and MRI/CT Report** □**All Records*** **Other:** _____

_____

"All records" means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers).

Persons, facility, or class of persons who are authorized to disclose (provide) the records/information:

Persons, facility, or class of persons who are authorized to receive the records/information:

X

Expiration: This "Authorization" will expire on _____(MM/DD/YY) or on the following specific event:_____
If no expiration date or event is listed unless otherwise revoked this authorization will expire in 1 year.

- This request for disclosure of medical records/information is made at my request.
- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal, or state law and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may revoke this authorization at any time by delivering/mailing a *written* revocation to the party or attorney or law firm named in Block 4 above.
- If I revoke this authorization, it will have *no* effect on actions already taken on reliance on this form.
- I also understand that the covered entity will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

Patient Signature Or if applicable, Patient's representative

X Date:

Personal Representative's Relationship/Capacity to Patient:_____
Printed Name of Personal Representative and Relationship to Patient:_____
Printed address & telephone number of Personal Representative_____

For Office Use Only

Initials of Person completing request: _____ Date Completed: _____
Patient to: __pick up records __mail records to patient __fax records __secure email records __other