SUMMIT PAIN CLINIC
6350 E. 2nd Street, Casper, Wy. 82609
Phone: (307) 232-3235
Fax: (877) 319-1834

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Please note that any missing information/blanks may result in a delay or inability to release information.

PATIENT NAME: ____ DATE OF BIRTH ____________________________
PATIENT'S ADDRESS: ____ CITY/STATE/ZIP ____________________________
PHONE # where you may be reached: Home________________________ Cell/other__________________________________

Disclosure of protected health information is made at my request for:
☐ Change of Insurance ☐ Referral ☐ Change of Physician ☐ Personal records ☐ Legal or attorney use

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED/CHECK ALL THAT APPLY:
☐ All Records of treatment ☐ Billing records ☐ Records from (date)________________to (date)____________________
☐ Lab/diagnostic results only ☐ Clinic notes ☐ Operative or procedure notes
☐ Radiology reports ☐ Link/QR Code of Radiology Images ☐ Other records (please specify)____________________________

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:
☐ Information pertaining to drug and alcohol abuse, diagnosis, or treatment (42 CFR 2.34 and 2.35)
☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code 5328, *et seq*.)
☐ Release of HIV/AIDS test results/Communicable Disease test results (Health and Safety Code 120980 (g))
☐ Release of genetic testing information (Health and Safety Code 124980 (j))

PLEASE CHECK ONE:

_____ **SUMMIT PAIN CLINIC is authorized <u>to disclose (provide)</u> the records/information. Persons, facilities, providers or others who are authorized <u>to receive</u> the records/information (Please fill in ALL appropriate contact information):**
Release to (Name):____
Release to (Address):____
City____ State_________________________ Zip_______________
Phone #______________________________ Fax # ____________________________________
Indicate method of delivery (check all that apply): _______ Mail ________ Fax ________ Call when ready, I will pick up

_____ **The Physician, Facility or Hospital named below is authorized to disclose (provide) the records/information <u>to SUMMIT PAIN CLINIC</u> (Please fill in ALL appropriate contact information):**
Requested from (Name):____
Requested from (Address):____
City____ State_________________________ Zip_______________
Phone #______________________________ Fax # ____________________________________
Indicate method of delivery: _______ Mail to 6350 E. 2nd Street, Casper, Wy. 82609 ________ Fax to 877-319-1834

Please complete more than one form if multiple disclosures to multiple providers is requested.

Unless otherwise revoked, the Authorization expires ____________________________ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form. Any services provided after the date of signing will require a new authorization to be completed.

NOTICE:
Summit Pain Clinic and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS:
This Authorization to release health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: 1) to conduct research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
This Authorization may be revoked at any time. The revocation must be in writing signed by you or your representative, and submit it to the Health Information Management Dept., Summit Pain Clinic, 6350 E 2nd St, Casper, WY 82609. The revocation will take effect upon receipt of request. You are entitled to receive a copy of this Authorization.
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.

____ _______________________
Signature of Patient (or Patient's Personal Representative, if applicable) **Date of Signature**
Personal Representative's relationship or legal ability to represent the patient____
Printed Name of Patient or Personal Representative: ____
Printed address & telephone number of Personal Representative: ____

OFFICE USE ONLY: (Please initial): ______ CD Only/Mail Report ______ CD _____ Mail _____ Fax ______ Patient Pick Up

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