SUMMIT PAIN CLINIC

6350 E. 2nd Street, Casper, Wy. 82609

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

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 ☐ CD 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 to disclose (provide) the records/information. Persons, facilities, providers or others who are authorized to receive 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 to SUMMIT PAIN CLINIC (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