Authorization for Use and Disclosure of Protected Health Information (PHI)

Record Request Form

Patients Last Name	First Name	Date Of Birth	Last 4 #'s of Social Security
Address	City	State	Zip Code

Facility/Doctors authorized to request 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 from: (this section must be filled out completely)

Facility or Doctor Name	Office Phone Number	Fax Number	
Address	City	State	Zip Code

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:

- O Insurance Reasons
- O Medical Care
- O Personal Reasons
- O Legal Reasons
- O Other: _____

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

O All PHI in the medical records	O Consultation Reports	O X-Ray Test/reports
O History and Physical reports	O Discharge Summary	O Laboratory Reports
O Progress Notes	O Itemized Billing Statements	O 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 redisclosed.
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	
Patient Representative Signature	Relationship	Date

Authorization for Use and Disclosure of Protected Health Information (PHI)

Record Release Form

Patients Last Name	First Name	Date Of Birth	Last 4 #'s of Social Security
Address	City	State	Zip Code

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Medical records to be released to:(this section must be filled out completely)

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Purpose of disclosure:

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

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

O	All PHI in the medical records	O	Consultation Reports	O	X-Ray Test/reports
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