PREMIER PAIN® CENTERS
An affiliate of National Spine & Pain Centers

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

I hereby authorize PPC to disclose my individually identifiable protected health information (PHI) as described here to the person/organization named below.

Section A. Complete all sections

Patient Name:	Birth Date:	Social Security No.:
Patient Address:		
Name and Address of person (s) or organization (s) to whom this information will be sent:		
Fax Number:	Phone Number:	

This authorization will expire on the following: (Fill in the Date or the Event but not both.). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

Date: _____ Event: _____

Purpose of disclosure:

Description of information to be released:

Medical record from (insert date) _____ to (insert date) _____

Check the appropriate boxes:

☐ Entire Record
☐ History and Physical
☐ Operative Reports
☐ Consultation Reports
☐ Laboratory Reports
☐ Medication Reports
☐ Radiology Reports
☐ Nursing Notes
☐ Physician Progress Notes
☐ Physician Orders
☐ Other: _____

The following information will not be released unless you specifically authorize its disclosure by *initialing* the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to mental health treatment
_____ I specifically authorize the release of information pertaining to alcohol and/or drug abuse
_____ I specifically authorize the release of information pertaining to confidential HIV(AIDS) related information

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester 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 the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the release of the protected health information as stated.

Signature of Patient or Representative Authorized by Law*:	Date:
Print Name of Patient or Representative Authorized by Law:	Relationship to Patient:

Section C: Office use only. Complete all sections.

Received by: _____ Date form received: _____

Delivery method: ☐ FAXED ☐ MAILED ☐ IN PERSON

Privacy Officer or Designee's signature authorizing release: _____

*REPRESENTATIVE AUTHORIZED BY LAW MUST SUBMIT COPIES OF LEGAL DOCUMENT SUPPORTING HIS OR HER AUTHORITY TO ACT ON THE PATIENT'S BEHALF.

Administrative Office
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