INTEGRATED PAIN SPECIALISTS

Authorization for Release of Information

Patient Name: Last First MI (Maiden or Other Name)

Date of Birth – MM/DD/YYYY Soc. Sec. Number

Street Address City/State Zip

Daytime Phone Number Nighttime Phone Number

I hereby authorize Integrated Pain Specialists to (check one): ☐ obtain ☐ release information from my medical record as indicated below to:

Name

Street Address City/State Zip

Phone Number Fax Number

Information to be released: ☐ **All records generated by Integrated Pain Specialists**
Date Range_____

☒ Physician Notes ☐ Lab Reports ☐ X-Ray Reports ☐ MRI Reports ☐ X-Ray/MRI/Images CD ☐ Other:_____	**I specifically authorize the release of information relating to:** ☒ Substance Abuse (including alcohol/drug abuse) ☒ Mental Health (including psychotherapy notes) ☒ HIV Related Information (AIDS related testing) **X**_____ Signature of Patient or Legal Guardian Date

Purpose of Disclosure:

☐ Changing Physicians	☐ Second Opinion	☐ Continuing Care	☐ Workers Comp.
☐ School	☐ Insurance	☐ Legal	☐ Disability
☐ Military	☐ Personal	☐ Other	☐ FMLA

1. I understand that this authorization will expire one year from date signed.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. It will be effective on the notification date unless action has already occurred prior to notification.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I may see and copy the information described on this form if I ask for it. I will get a copy of this form after I sign it.
6. I understand that in compliance with Nebraska statute there may be a fee for requested records. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

X_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____ _____ _____
Records Received By Date Relationship to Patient

FOR OFFICE USE ONLY

Date Request Filled:_____ By_____Acct#_____
Identification Presented:_____ Fee collected:$_____