LifeLincPain Centers℠

Authorization to Disclose (Release) and Use Protected Health Information

This Authorization relates to your health information and its purpose is to permit your health information, as you specify, to be disclosed for the purposes described below. Unless otherwise stated below, your ability to receive treatment, payment, or enrollment or eligibility for health benefits cannot be conditioned on you signing this form. You do not have to sign this form, but if you do not, your health information cannot be released to the recipient you identify below. Note: This form cannot be used to prohibit disclosures otherwise required or permitted by law.

1. Patient's full name (*please print*): ____

Address: ____

City: ______________________________ State: _______________ Zip: ___________

Date of birth: ______ /______ /_______ Patient SSN: ____________________________

2. I authorize the release and use of the following information from my records: _______________

□ Complete medical record □ Progress note(s) □ Procedure note(s) □ Billing/Payment information

I understand that the information disclosed may include information about diagnosis and/or treatment for alcohol abuse, drug abuse, psychiatric or mental illness, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and/or other sexually transmitted diseases.

3. I authorize my health care providers **to <u>disclose</u>** (release) such information about me to:

Recipient's name (*or type*): ____

Address (*if known*): ____

City: ______________________________ State: _______________ Zip: ___________

4. The information is being released at the request of the patient. The purpose or need for the information is ____

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Expiration: Unless otherwise revoked by you, this Authorization shall remain in effect for a period of six (6) months. **Consequences of signing this form:** Under federal privacy regulations, if you authorize disclosure of your health information for a purpose beyond treatment, payment, or health care operations, it is possible that your health information might later be redisclosed and no longer protected by federal privacy regulations. **Revocation:** You may revoke this Authorization in writing at any time, except to the extent someone has already relied on it. If applicable, you may not have the right to revoke this Authorization to the extent it pertains to an insurer's right under law to contest a claim under your insurance policy.

______________________________ ______________________________

Signature of patient Printed name of patient

____

Date

For Office Use Only □ All complete □ I.D. verified □ Signed copy to patient

Processed by: ______________________________________ MRN ____________________