

# Authorization for Use and Disclosure of Protected Health Information

(Form MUST be filled out in its entirety or it will be returned)

Advanced Pain Medicine, PSC  
101 Prosperous Place, Suite 300  
Lexington, KY 40509

Phone: (859) 271-3114 Fax: (859) 271-0220

PATIENT NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(Street)

(Apt. #)

(City)

(State)

(Zip)

PHONE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## I hereby authorize Advanced Pain Medicine, PSC to:

Release my records to:

**-OR-**

Retrieve my records from:

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #:( \_\_\_\_\_ ) \_\_\_\_\_

Phone #:( \_\_\_\_\_ ) \_\_\_\_\_

Fax#: ( \_\_\_\_\_ ) \_\_\_\_\_

Fax#: ( \_\_\_\_\_ ) \_\_\_\_\_

### Information Requested:

- Complete Medical Record
- Office Visits
- Labs
- Imaging Reports
- Physical Therapy Notes
- Behavioral Medicine Reports
- Other \_\_\_\_\_

Time Period: From \_\_\_\_\_ to \_\_\_\_\_

I understand the information released may contain information relating to alcohol and/or drug abuse, drug tests and/or lab results, psychiatric diagnoses, and/or mental health information, communicable diseases including HIV and Sexually transmitted diseases.

(must be checked in order to receive this type of Info.)

\* I authorize this disclosure for the purpose of allowing the above-named doctor to provide medical care to me and do so at my request as a patient.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of the patient or the patient's duty authorized representative

\_\_\_\_\_ Date: \_\_\_\_\_

Description of the authority of the patient's personal representative (if applicable)

### STATEMENT OF PATIENT RIGHTS:

- A. I understand that I may revoke this authorization at any time by providing a signed and dated revocation in writing to the disclosing entity or person identified above. This written revocation will take priority over this authorization, except to the extent that the disclosing entity or person has already disclosed health information prior to the receipt of my written revocation.
- B. I understand that treatment, payment, and other benefits may not be conditioned upon my signing of this authorization.
- C. I understand that health information disclosed pursuant to this authorization may be re-disclosed by the receiving entity or person without my knowledge or permission.
- D. I am entitled to receive a copy of this authorization.