AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

ALAVIE INTERVENTIONAL PAIN MANAGEMENT

Fill out form in its entirety. If any section is incomplete, this form may be invalid & the request may not be processed.

Today's Date: _____	Patient Name: _____ DOB: _____ Phone number: _____ Address: _____

Release Information To:	**Obtain Information From:**
Provider/Facility Name: _____ Address:_____ Phone: _____ Fax: _____	Provider/Facility Name: _____ Address:_____ Phone: _____ Fax: _____

Check specific item(s) to be released:

☐Entire Medical Record ☐Operative/Procedure Notes ☐Office Visit Notes

☐Radiology Reports ☐Laboratory/Pathology Reports ☐Other:_____

I do not want the following information disclosed:

☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AIDS ☐ Alcohol/Drug Abuse ☐ Genetic Information

The undersigned patient (or personal representative on behalf of the patient) hereby authorizes the Provider named above to release the Health Information described above to the Recipient named above. The patient has the right to refuse to sign the authorization.

The provider cannot condition treatment, payment, enrollment, and eligibility for benefits on the patient providing this signed authorization.

This authorization to release the health information listed above can be revoked at any time (upon written notification to the recipient at the above address) except to the extent that Provider has already released the Health Information before obtaining receipt of the revocation.

When the Patient's health information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the Recipient or any of its agents and/or employees and may no longer be protected by 45 CFR parts 160 and 164.

_____ _____

Signature of Patient/patients representative Date

_____ _____

Printed name of patients representative Date