Pain Treatment Centers of America & Interventional Surgery Institute

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Little Rock, AR 72205
Phone: 501-773-6993 Fax: 888-630-8885

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

Name:_____ Date of Birth:_____
Last Name First Name Middle Initial

Address:_____
Street Apt #

_____
City State Zip Code Patient SSN

Telephone Number (including area code):_____
Home Phone Work Phone Cell Phone

I authorize PTCOA to: _____ **obtain medical records from: (*e.g. another doctor*)**
_____ **release medical records to: (*e.g. another doctor*)**
_____**share medical information/records with (*e.g. family/friend)***

Name/Facility:_____ Relationship:_____
Address:_____ PH:_____
_____ FAX:_____
(more space on back of form)

RELEASE THESE RECORDS Patient's Initials

1. All medical records _____
2. Specific records _____

I authorize the release of the above information with the exception of:
_____ Substance abuse, if any. _____ AIDS/HIV, if any. _____ Psychological/psychiatric records, if any.

This authorization will remain in effect indefinitely or until revoked in writing.

Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization may deny the release of protected health information, if it has reason to believe (1) this authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested.

I understand that I have the right to:

> Revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to PTCOA. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to PTCOA when the law provides it the right to contest a claim under my policy.

> I understand that I do not have to sign this authorization and that PTCOA may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

> I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

> Right to Copy/Voluntary Disclosure: I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

Signature of Patient or Legal Representative:_____Date:_____

If signed by Legal Representative, relationship to Patient:_____

If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will, or Guardianship Papers.

_____
Preparer's Initials