## ADVANCED PAIN INSTITUTE, LLC

## Authorization for Release of Protected Health Information to Advanced Pain Institute, LLC

### Patient Information

Printed Name: ________________________________ __ Date of Birth: ______________________________
Address: ___________________________________________________________________________________
___________________________________________________________________________________

Social Security #: ___________________________ Telephone: ________________________________

### Authority to Release Protected Health Information

I hereby authorize _________________________________to release the information identified in this authorization form from the medical records of _________________________________ and provide such information to:

**Advanced Pain Institute LLC, 42131 Veterans Avenue, Suite 100, Hammond, LA 70403 – Fax #(985) 345-7249**

### Information to Be Released – Covering the Periods of Health Care

From (date) _______________________________ to (date) __________________________________

*Please check type of information to be released*

| | | |
|---|---|---|
| ( ) **Complete health record** | ( ) Diagnosis & treatment codes | ( ) Discharge summary |
| ( ) History and physical exam | ( ) Consultation reports | ( ) Progress notes |
| ( ) Laboratory test results | ( ) X-ray reports | ( ) X-ray films/images |
| ( ) Photographs, videotapes | ( ) Immunization Records | ( ) Itemized bill |

( ) Other, (specify) ___________________________________________________________________________

### Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be “at the request of the individual”):

_____________________________________________________________________________________________

_____________________________________________________________________________________________

### Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
Check One: ( ) Yes ( ) No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. Check One: ( ) Yes ( ) No

### Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to Advanced Pain Institute, LLC, ATTN: Medical Records Manager at 42131 Veterans Avenue, Suite 100, Hammond, LA 70403. Unless revoked, this authorization will expire on the following date, or after the following time period or event _________________________________.

### Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

### Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information released to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge Advanced Pain Institute, LLC of any liability and the undersigned will hold Advanced Pain Institute, LLC harmless for complying with this Authorization.

Signature: ____________________________________________ Date:
_______________________________________

Description of relationship if not patient: ______________________________________________________________