RIVER CITIES
INTERVENTIONAL
PAIN SPECIALISTS

AUTHORIZATION TO DISCLOSE PROCTECTED HEALTH INFORMATION

_____ _____

Printed Name of Patient | Previous Names, if applicable

_____ _____

Date of Birth | Day Telephone Number

SEND INFORMATION TO: (Please be specific)

Provider Name/Organization:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#:_____

INFORMATION TO BE RELEASED FROM: (Please be specific)

Provider Name/Organization:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#:_____

PURPOSE OF DISCLOSURE: ☐ Transfer of Care ☐ Self ☐ Specialist ☐ Other (Must Complete)

INFORMATION TO BE DISCLOSED:

☐ Medical Records from last two years

☐ Summary Health Information

☐ Complete Designated Record Set Dates of Service: _____

☐ Other_____ Expiration Date (or event) _____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated with 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPPA of 1996. I acknowledge that I have received a copy of the Notice of Privacy practices. _____ (Initials)

_____ _____ _____

Date **Signature of Patient or Representative** **Relationship to Patient**

My signature below specifically authorizes the release of Healthcare information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS Virus ☐ Mental Health/Psychiatric Disorders

☐ Sexually Transmitted Diseases ☐ Drug, Alcohol Abuse/Treatment

_____ _____ _____

Date **Signature of Patient or Representative** **Relationship to Patient**