INNOVATIVE
PAIN AND WELLNESS™
Future. Personal. Hope.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's name: _____Date of Birth: _____

I request and authorize **Innovative Pain and Wellness**, to disclose healthcare information regarding the above named patient to:

Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Description of Protected Health Information to be disclosed:

☐ Complete Medical Record ☐ Urine Drug Screens ☐ Lab Tests

☐ All diagnostic reports (EMG, CT, MRI, X-ray) ☐ Other: _____

Purpose(s) of the disclosure:

☐ Continuity of Care ☐ Transfer of Care ☐ Personal Use

☐ Second Opinion ☐ Supplemental Care ☐ Legal

☐ Insurance Coverage or Payment of Care ☐ Other: _____

I hereby authorize Provider to release Protected Health Information ("Information") to Innovative Pain and Wellness. I understand that this authorization may cover information relating to: (i) AIDS, HIV and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental and behavioral health and treatment; and (iv) alcohol, drug and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before and revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eight (180) days following the date of execution. I understand that a photocopy of facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

_____ _____

Signature of Patient or Patients Legal Representative Date

_____

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.