Authorization for Disclosure of Protected Health Information

Patient Name: _____ DOB: ____ / ____ / ____
Social Security Number: _____ Phone Number: _____
Maiden/Previous Names/Nicknames: _____

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

Request information from:	**Request information to:**
Provider/Facility Name:	Provider/Facility Name: Alliance Pain Management
Address:	Address: 1111 E Lamar Alexander Parkway
City/State/Zip:	City/State/Zip: Maryville, TN 37804
Phone Number:	Phone Number: 865-724-0867
Fax Number:	Fax Number: 865-233-0592

Purpose of Release:
☐ Continuing Care ☐ Personal ☐ Transfer of Care ☐ Disability Determination ☐ Legal ☐ Work Comp
☐ Insurance ☐ Other: _____

Information to be Released: Service Dates: From: _____ To: _____
☐ Entire Medical Record ☐ Lab Reports ☐ Operative/Procedure Notes ☐ Radiology Reports
☐ Records pertaining to HIV or Hepatitis ☐ Psychiatric Records
☐ Office Visit Notes ☐ Billing Statements ☐ Other (Please Specify): _____
_____

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Refuse to Sign This Authorization: I understand that I have the right to refuse to sign this Authorization and APM will not condition treatment or payment upon my signing of this Authorization.

Right to Revoke Authorization: I understand that I have the right to revoke this Authorization, except to the extent that APM has already disclosed my medical information in reliance of this Authorization. I understand that my revocation is effective only if it is in writing. To revoke my Authorization, I understand that I must send a written request for revocation to APM.

Re-disclosure of Information by Recipient: I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person(s)/organization(s) receiving my medical information and no longer protected by applicable privacy laws.

Right to Receive a Copy of This Authorization and My Medical Information. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I also have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization.

By signing this form, I am authorizing APM to disclose my medical information as described in this Authorization.

Signature: _____ Date: _____

Printed Name of Person Signing (if not patient): _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Activated Power of Attorney ☐ Next of Kin