IMS PAIN MANAGEMENT
A DIVISION OF IMS

Expert orthopedic care in your neighborhood

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____to disclose the following information from the health record of:

PATIENT INFORMATION		____/____/____
	Patient Name	Date of Birth
		( )
	Address	Phone Number
	City State	Zip Code
	Dates of Service: From _____To_____	

INFORMATION REQUESTED

[ ] All Pertinent Records
[ ] Assessment(s)
[ ] Consultation
[ ] Discharge Summary
[ ] ER Report
[ ] History & Physical
[ ] Operative Report
[ ] Pathology Report
[ ] X-Ray Films
[ ] X-Ray Reports
[ ] Billing Record
[ ] Specify:

PURPOSE [ ] Self [ ] Continuing Medical Care [ ] Attorney Request
[ ] Other (specify reason) _____

INFORMATION TO BE GIVEN TO:

_____ ( ) _____ ( ) _____
Company, Person, Facility Phone Number Fax Number

_____
Address City State Zip Code

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. IMS Pain Management Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, **it will expire 12 months from the date signed** or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release IMS Pain Management, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient **Date**

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

_____ _____
Signature of Legal Represents Relation to Patient or Description of Authority to Act for Patient **Date**