**AUTHORIZATION FOR RELEASE OF INFORMATION FROM NOBLE PAIN MANAGEMENT AND SPORTS MEDICINE**

I hereby authorize Noble Pain Management and Sports Medicine to disclose my individually identifiable health information as described below, which may include information concerning treatment, medical history, chemical or alcohol dependency, laboratory test results, communicable diseases, mental illness, or any such related information. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider; the released information may no longer be protected by federal and state privacy regulations. To prevent delay, please fill out this form in its entirety.

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dates of Service (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR □ ALL**

**Description of information to be released:**

\_\_\_ Physician’s Notes \_\_\_ Radiology/Laboratory \_\_\_ Emergency Room

\_\_\_ Operative Reports \_\_\_ Billing Records \_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of the purpose of the use and/or disclosure: (Check ✓ the appropriate category)**

\_\_\_ Hospital \_\_\_ Physician \_\_\_ Insurance Company \_\_\_ Attorney \_\_\_ Patient \_\_\_ Other \_\_\_\_\_\_\_\_\_

**Name of Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that this authorization will expire by 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_\_\_\_\_\_\_ (Expiration date/event)

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed above. I also understand that the written revocation must be signed and dated with the date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the revocation.

I understand and agree that there may be costs associated with this request in compliance with State copying laws.

**Signature of Patient or Legal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Patient Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Authority \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (attach supporting documentation)**