Pain Management of NC

285 Olmsted Blvd, Suite 1, Pinehurst, NC 28374 Phone: **(910) 295.7246** Fax: **(910) 222.3168**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM PAIN MANAGEMENT TO NORTH CAROLINA

______________________________________ ______________________________
Please Print Patient's Full Name Birth Date: Month Day Year

______________________________________ ______________________________
Street Address Social Security Number

______________________________________ ______________________________
City State Zip Phone (home number)

At the request of the individual, I ________________________, do hereby authorize Pain Management of NC to release
(Patients Name)

____ DISCHARGE SUMMARY	____ PATHOLOGY REPORTS	____ EMERGENCY REPORTS
____ HISTORY & PHYSICAL	____ LABORATORY REPORTS	____ OTHER ________________________
____ PROGRESS NOTES	____ RADIOLOGY REPORTS	________________________
____ OPERATIVE NOTES	____ ECG/EEG/CARDIAC CATH	________________________

□ **I DO** □ **I DO NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or physiological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

PAIN MANAGEMENT OF NC
285 Olmsted Blvd, Suite 1
Pinehurst, NC 28374

or

FAX
(910) 222.3168

PURPOSE OF DISCLOSURE:

____ REFERRAL TO SPECIALIST	____ LEGAL INVESTIGATION	____ INSURANCE	____ WORKER'S COMP
____ DISABILITY DETERMINATION	____ CHANGE OF DOCTOR	____ PERSONAL	____ CONTINUING CARE

____ OTHER (SPECIFY) ____

Please provide a current telephone number in the event we need to contact you: ______________________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized / furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________________ ______________________________
Signature of individual or guardian or Personal Representative of patient's estate **Date**

____
Signature of Witness