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 OF 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: ______________________________
Name of Company/Agency/Facility/Person

____
Street Address

____
City, State, Zip

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**