SEPA PAIN + SPINE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date of Birth:

Address: Phone #:

Previous Name: Social Security #:

I request and authorize ______________________________ to release healthcare information of the patient named above to:

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip Code: ____________

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates:

____

□ All healthcare information

□ Other: ______________________________

□ Limitations to information to be provided, please specify:

□ Yes □ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Signature of Patient / Legal Guardian Date

Relationship to Patient

Signature of Witness Date

If patient is physically unable to provide a signature and desires to consent to the release, print his/her name & information in above form and record the signatures of two (2) responsible persons who witness that the patient understands the nature of this release and freely gave his/her consent

Signature of Witness Date

Signature of Witness Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED AND CAN BE REVOCABLE AT ANY TIME

Updated: May 2019