CLEAVER MEDICAL GROUP
THE CENTER FOR INTERVENTIONAL PAIN MANAGEMENT

MIRANDA REED CLEAVER, D.O.
COLIN KRESS, D.O.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ______________________________ DOB: ______________

Last 4 of SSN: ______________

Address: ____

City: ____________________ State: ____________ Zip: ______________

Email: ______________________________ Phone: ____________________

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid, and the request may not be processed.

Request Information From:	**Release Information To:**
Provider/Facility Name: ______________________	Provider/Facility Name: ______________________
Address: ______________________	Address: ______________________
City/State/Zip: ______________________	City/State/Zip: ______________________
Phone: ______________________	Phone: ______________________

- Cleaver Medical Group Center for Interventional Pain Management (CMG) has my permission to use or give out certain information in my medical record – called "protected health information" (PHI). The information that CMG may give out is checked below.

- I also understand that PHI may include information protected under Federal and State Law (such as information about alcohol, drug abuse, mental health, HIV, and/or AIDS treatments).

Information to be Released:

- ☐ Entire Record
- ☐ Clinic Progress Notes
- ☐ Radiology Reports
- ☐ Lab/Pathology Reports
- ☐ Other: ______________________________________

Reason:

- ☐ Change of Insurance.
- ☐ Transfer/Continuity of Care
- ☐ Personal File
- ☐ Moving
- ☐ Other: ______________________________________

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Expiration of Authorization

I understand that I may revoke this authorization at any time by sending written notice to CMG Medical Records Department at the address noted below. I understand that revocation will not apply to PHI that has already been released in association with this authorization.

ATTENTION: Please review the information carefully. If information is missing the request may not be processed.

- **If the patient is 18 years of age or older, the patient must sign and date the form.**
- **If the patient is 18 years of age or older, and lacks the capacity to sign,** a legally authorized person may sign and date the form.
  Please indicate your legal authority and include documentation of your relationship.
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form. Please indicate your relationship.
- **If the patient is deceased,** the patient's legal next of kin or authorized representative must sign and date the form.

I have read and understand that this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person with permission to act on the Patient's behalf. I will not hold Cleaver Medical Group, its officers, trustees, employees, agents, or contractors responsible for anything that may happen from the use or release of my PHI. This authorization will expire in one (1) year from the date of signing unless I revoke in writing, or indicate an event or earlier date here: ____________________

Print Patient Name

____

Patient Signature

____

Date Signed (required):

____

Print Patient's Authorized Representative Name

____

Signature of Patient's Authorized Representative

____

Date Signed (required):

____

Documentation Required

To ensure we are releasing medical records to an authorized party, we ask that you make the following documentation available to us upon your request.

Patients Requesting Their Own Medical Records:

- Signed Medical Release Form
- Government issued photo ID (Driver's License, Passport, etc.).

Please note that patients requesting a copy of their own records are subject to a processing fee.

Patient Representative Picking Up Medical Records Requested by Patient:

- Signed Medical Release Form
- Government issued photo ID of the patient and the patient's representative (Driver's License, Passport, etc.).

Third Party or Patient's Representative Requesting Medical Records:

- Signed Medical Release Form
- Government issued photo ID of the patient and the patient's representative (Driver's License, Passport, etc.).
- Durable Medical Power of Attorney
- Death Certificate
- Executer of Estate Documentation
- Court Order, Subpoena, Production of Documents.