CORVALLIS
pain management

LIMITED DISCLOSURE AUTHORIZATION

TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

I authorize Corvallis Pain Management to disclose the following limited protected health information. I understand that this is for **verbal** interactions only. Paper records will need another release form.

PLEASE SELECT THE TYPES OF HEALTH INFORMATION YOU AUTHORIZE TO BE DISCLOSED:

APPOINTMENT DATES/TIMES: _____

PRESCRIPTION REFILLS/INSTRUCTIONS: _____

LAB RESULTS: _____

IMAGING RESULTS: _____

BILLING INFORMATION: _____

ALL OF THE ABOVE: _____

OTHER: _____

Please provide first and last name(s), phone number(s), and relation to patient.

_____ (FIRST) _____ (LAST)

_____ (PHONE) _____ (RELATIONSHIP)

_____ (FIRST) _____ (LAST)

_____ (PHONE) _____ (RELATIONSHIP)

This authorization may be in effect from **ONE YEAR** of signing date **OR YOU CAN SPECIFY THE DATES** you with this authorization to be effective for:

FROM: _____ TO: _____

PATIENT SIGNATURE: _____ **DATE:** _____