PREMIER PAIN CONSULTANTS

Medical Records Release Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of health information as follows:

Patient Name: _____ MR#_____

Date of Birth _____ Date of Discharge *(if applicable)* _____

The following individual/ organization is **authorized to make the disclosure**:	Name of Provider:	_____
	Address of Provider:	_____
		_____
	Phone and Fax #:	_____
The following individual/ organization **authorized to receive this information**:	Name of Organization:	Premier Pain Consultants
	Address of Provider:	150 Laguna Suite A Fullerton, CA 92835
	Phone and Fax #:	(714) 525-8822*(714) 525-5193

This Authorization applies to the following information (please select only **one** of the following):

[ ] All of my health information that the provider has in his or her possession, including health relating to any medical history, mental or physical condition and any treatment received by me, including without limitation: x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that may be held.

[ ] All of my health information described above except for the following:
_____

[ ] Only the following records or types of health information (types of treatment or other designation):
_____ Dates: _____

SIGNATURES

Signature _____ Date ___/___/___ Time _____AM/PM
[patient/representative/spouse/financially responsible party]
If signed by someone other than the patient, state your legal relationship to the patient: _____
[A spouse or financially responsible party may only authorize the release of the medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service plan or employee benefit plan.]

Witness _____ Date ___/___/___ Time _____AM/PM