Authorization For Use And/Or Disclosure Of Protected Health Information

I give permission to : _____

(Name of Organization Allowed To Release Medical Records)

Address **City** **State** **ZIP**

Radiology Fax: _____ **Med. Rec Fax :** _____

To be released for use to : **Allied Pain Institute**

14777 Los Gatos Blvd. Ste. 202 **Los Gatos, CA 95032**

Disclosure:

The personal health information, when received, will be used solely for the purpose of review and familiarization with the status of injury of the patient seeking treatment. The records cannot be duplicated or disclosed to any other person or party unless written permission is given or the law allows it.

Please Release The Medical Information, As Identified In This Authorization, Pertaining To:

Last Name	First Name	Date of Incident
Med Rec Number/ SS#	Date of Birth	Telephone Number

Medical Records Requested: Limitations: _____ Yes _____ No

Complete Records: _____ (Please Initial) For Month Of: _____ Year: _____

Please Include All: Diagnosis Examinations Treatments Progress Notes

Films & Reports: _____ X-Ray Films _____ X-Ray Report _____ Both R & F

_____ MRI Films _____ MRI Report _____ Both R & F

If Applicable Initial For The Release Of The Following:

Drug/Alcohol Treatment _____ Initial Genetic Testing _____ Initial

Results Of Lab Requests _____ Initial HIV Blood Test Results _____ Initial

Mental Health Records Signature: _____ Date : _____

Other Information (Please Specify): _____

Re-Disclosure: This authorization is effective immediately and will be valid for one year from the date signed. I have the right to receive copy of this authorization if requested. Authorizing me the right to cancel said authorization at any time; cancellation must be in writing and will be effective at the time notice is received. I further understand that treatment, payment, enrollment & eligibility for benefits will not be determined based on my permitting / refusing to sign the authorization except if my treatment or healthcare services are given to me only for creating protected health information for release to a third party or appointed attorney. I also reserve the right of refusing to sign the authorization. I have read and understand the terms & conditions of the authorization.

Patient/Representative Signature : _____ Date : _____

If signed by representative, state relationship: