



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Form is Fillable**

Patient's name: _____ Date of Birth: _____

Release Information from:

I request and authorize (records from):

Facility: _____

Phone: _____ Fax: _____

Send Records to:

Facility: _____

Phone: _____ Fax: _____

Description of Protected Health Information to be disclosed:

- Complete Medical Record Urine Drug Screens Lab Tests
 All diagnostic reports (EMG, CT, MRI, X-ray) Other: _____

Purpose(s) of the disclosure:

- Continuity of Care Transfer of Care Personal Use
 Second Opinion Supplemental Care Legal
 Insurance Coverage or Payment of Care Other: _____

I hereby authorize Provider to release Protected Health Information ("Information") to Advanced Spine and Pain. I understand that this authorization may cover information relating to: (i) AIDS, HIV and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental and behavioral health and treatment; and (iv) alcohol, drug and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before and revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eight (180) days following the date of execution. I understand that a photocopy of facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

Signature of Patient or Patient's Legal Representative

Date

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.

Advanced Spine and Pain
P: 480.573.0130 F: 480.573.0131

Please Send Completed Form to: info@asappaindocs.com