

west chester

PAIN MANAGEMENT

7862 Kingland Drive*Suite 201*West Chester, OH 45069
Phone (513) 755-1341 * Fax (513) 755-5342

Date:

Patient Name:

DOB:

Social Security#:

*******Records Requested: PLEASE FAX ASAP TO 513-755-5342*******

This permission includes release of information to provide continuity of care, to asset assessment and/or treatment planning for processing and insurance claim or to meet another specific desire of mine. I specify that this release is to include a summary deemed appropriate by the physician(s) at our office unless otherwise requested.

I authorize the use or disclosure of the above named individual's health information

The type of information to be used or disclosed (including HIV testing, AIDS related treatment, drug and alcohol abuse and treatment, drug related conditions, alcoholism, psychiatrics or psychological conditions):

Medication list, most recent office note or ER note, testing (MRI, X-RAY, EMG, MYELOGRAM DISCOGRAM) related surgical notes

The information identified above may be used or disclosed to the following: Back & Spine Center of West Chester, Inc.

This information which I am authorizing disclosure will be used for: Continuation of medical care

I realize that I may be charged for any or all of the medical information I have asked to have released to or from this office.

The following organization authorized to make the disclosure:

Name:

Street Address:

City, State, Zip Code:

Phone/Fax:

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records for the purpose and extents stated above and release the above named institute of any claim pertaining to the release and use of medical data or the contents thereof. I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing. This does not apply to information already released. **Authorization expires 1 year from date of signature.** May be revoked at any time. Information may be redisclosed pending proper authorization.

Name: _____

Signature: _____