AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Mays and Schnapp Pain Clinic and Rehabilitation Center and Pain Clinic Associates, P.C.
55 Humphreys Center Drive, Suite 200, Memphis, TN 38120

PATIENT'S NAME: _____ BIRTH DATE: _____ SS #: _____

ADDRESS: _____

I authorize Practice or the following person or organization (specify if applicable) _____ **to**:

☐ **disclose** my health information to: _____
(Name and Address) - Specify: Attorney, Insurance, Self, etc

☐ **obtain/request** copies of my health information from: _____
(Name and Address) - Specify: Hospital, Doctor, etc

Purpose of use, disclosure, and or request: ☐ Continuation of Care/Treatment ☐ Attorney ☐ At the request of the patient
☐ Payment ☐ Other, specify: _____

I authorize use and/or disclosure of information covering treatment from: _____ to: _____
(enter specific dates)

Information to be used and/or disclosed:
☐ Clinical record (Example: History and Physical, Progress Notes, and Pathology Report, if applicable)
☐ Itemized bill
☐ Other (Specify) _____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).

This authorization will expire (**90** days) from the date of your signature unless you specify a different expiration date, event, or condition. Please specify: _____

I understand that I have a right to revoke this authorization at any time, except to the extent that release of information has already occurred in reliance on my prior authorization.

I understand that in order to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to the Privacy Officer at the Practice address indicated above. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as workers' compensation, private health insurance, application for insurance, etc., my refusal to sign may effect payment, enrollment or eligibility for benefits. This, in turn, may effect payment for services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

When Practice **seeks** an authorization for its own use or disclosure of protected health information (e.g., marketing, research , etc.), a **copy** of the authorization is provided to the patient.

_____ _____
Date | Patient (or person authorized to consent for minor patient who is unable to sign)

_____ _____
Witness | Relationship and/or authority to act for the patient

Photo ID was provided: Yes ☐ No ☐ If no, specify form of patient identification: _____