AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____

Telephone:_____ Social Security:_____

"I herby authorize this practice to make uses and disclosure of my protected health information) information about me in my medical records and/or financial records) as indicated below."

THIS INFORMATION IS TO BE DISCLOSED TO:

Emerald Coast Pain Services
3997 Commons Drive, Suite M
Destin, FL 32541
(850)424-3769
(850)460-2491 fax

Facility to disclose information:
Name:_____

Address_____

Telephone:_____ Fax:_____

Description of medical information to be disclosed:

Reason for requested use or disclosure:

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
c. The practice will not condition treatment or payment based on my signing this authorization
d. I am signing this authorization freely
e. No one has pressured me to sign this authorization
f. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law
g. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use
h. I have received a copy of this authorization

Patient signature: Date:

Signature of Patient's Representative: Relationship:

Event or Date Upon Which Authorization will expire:

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____

Telephone:_____ Social Security:_____

"I hereby authorize this practice to make uses and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below."

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Patient Signature Date

Signature of Patient's Representative Relationship

Event or Date Upon Which Authorization will expire:_____