Authorization to Obtain and Disclose Medical Information

Patient Information:

Name (Last, First, MI): Other Names:	
Address:	
	Date of Birth:

Please OBTAIN Information from the Following:

Physicians Pain Services
Name of healthcare provider 4800 Mexico Road St. Peters, MO 63376
Address
(636)442-5035 (phone), (636) 442-5036 (fax)
Phone/fax

Please SEND my Health Information to:

Name of healthcare provider
Address
Phone/fax

Information to be disclosed:

- Complete copy of official medical record (All notes, all pathology reports, all clinic summaries, x-ray/MRI, lab reports…)
- Most recent 2 years of complete record
- Records pertaining to the following dates or conditions

**If the information to be disclosed contains any of the types of special information below, additional laws relating to the use and disclosure of it apply. With my initials, I authorize disclosure of it apply. With my disclosure, I authorize disclosure of the following information.

_____Mental Health Information _____Developmental Disabilities

_____Alcohol or drug treatment _____HIV/AIDS- related information or results

Duration: This Authorization will begin immediately and remain in effect until _____ or not more than one year from authorization date below

Restrictions: I understand that if the persons or organization authorized by this form to receive my medical information are not healthcare providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release my medical information without my prior permission.

Rights: I understand that I am under no obligation to sign this form, and that my refusal to sign will not affect my ability to obtain treatment. I have the right to inspect or copy the medical information authorized here, with certain exceptions provided under state and federal law. I understand I have the right to revoke this authorization, in writing, at any time before it ends, and Physicians Pain Services has 30 days to comply with my written request. My written revocation will not affect any disclosures of my medical information that the persons/organizations have already made, in reliance on this authorization, before the time I revoke it.

Copying fees: If I am requesting disclosure/release of medical information to the other hospitals, clinics, or healthcare providers for further medical care, no copying fees will be charged, I must pay for copies I request for other purposes.

Signature: I have read this authorization, or had it read to me, and I understand it.

Signature	Date