Advanced
PAIN CONSULTANTS

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Advanced Pain Consultants, PA 3200 Blue Ridge Road, Ste 216 Raleigh, NC 27612 (919) 510-7901 (Phone) (919) 510-7902 (Fax)	Patient Name_____ Medical Record Number_____ Date of Birth_____ Phone Number_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize and request Advanced Pain Consultants, PA, to release the following noted Protected Health Information of the patient listed above to: _____
(Person/Physician/Entity to RECEIVE records-be specific)

□ To be mailed to:_____
_____

The specific information for the following dates of service:_____

INFORMATION TO BE DISCLOSED (check the appropriate boxes and include other information where indicated):
□ Summary Health Information
(Includes: Discharge Summary, Operative Report/Procedures, Radiology, Clinic Notes)

□History and Physical (e.g. Doctor Visit)
□Discharge Summary
□Operative Report
□Immunization Records
□Entire Records
□Other:_____
□Laboratory Reports
□Radiology Reports
□Emergency Department Reports
□Physical Therapy /Occupational Therapy Reports
□Patient Discharge Instructions

□Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, diagnosis, and treatment to date.

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:

□Fax to MD for Continuing Care
□Sharing with other health care providers'
□Legal Reasons
□Other_____
□Insurance Processing
□Personal Use

This authorization shall cover actions by and for Advanced Pain Consultants, PA. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to Advanced Pain Consultants, PA.

_____ _____ _____ _____
Signature of Patient or Legal Representative **Date** **Time** **Signature of Witness**