

AUTHORIZATION FORM FOR USING AND DISCLOSING HEALTH INFORMATION

A & A Pain Institute
555 N. New Ballas, Suite 165
St. Louis, Mo. 63141
Phone 314-692-7246 Fax 314-692-8716

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization/person authorized to receive the information is not a health plan or health care provider; the released information will on longer be protected by federal privacy regulations.

Patient's Name: _____

Date of Birth: _____

SS #: _____

Person/Organization Providing the Information: _____

Phone #: _____

Fax #: _____

Person/Organization Receiving the Information: A & A Pain Institute

Specific Information Requested (Including dates): All medical notes, radiology reports and labs pertinent to care of the patient.

The patient or representative must read and initial the following:

1. I understand that this authorization will expire on ___/___/___ Initials_____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. It will not have any effect on the actions they took before they received the revocation. Initials_____

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient's signature: _____

Date: _____

Patient's representative: _____

Date: _____

Description of Representative's Authority: _____