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Get Back To Living Life

CONSENT TO OBTAIN AND RELEASE PROTECTED HEALTH INFORMATION

1. I understand that my medical records currently contain or will in the future contain sensitive information. Unless otherwise indicated below, I consent to the release of such information as part of my medical record to insurers, billing service agents and other providers for the purpose of obtaining treatment for me, and so that these entities can carry on their health care operations.

2. I understand that Integrative Pain Clinic (henceforth referred to as IPC) require details regarding your health history in order to provide care to you. I specifically consent to the release of such information as listed below from the following facilities:

Phycian Name: ____________________ Phycian Name: ____________________

Facility Name: ____________________ Facility Name: ____________________

Other: ____________________ Other: ____________________

____

3. The following information will be requested from your health care providers:

- ☐ History and physical exam;
- ☐ Progress notes;
- ☐ Lab reports including
- ☐ HIV/AIDS status;
- ☐ Information regarding treatment for substance abuse (alcohol or drug);
- ☐ X-Ray reports
- ☐ Information related to mental health including psychotherapy notes, social history and assessment;
- ☐ Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor, or other allied health human services professional

4. I understand that I may revoke this authorization at any time by notifying Integrative Pain Clinic in writing, and it will be effective on the date noted except to the extent that action has already been taken in reliance upon this authorization. I further understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

- ☐ I agree to allow IPC to obtain and release the above information
- ☐ I do not agree to allow IPC to obtain or release the above information
- ☐ I agree to allow only the following information to be obtained and released by IPC:

____

Patient Name DOB

____________________ ____________________

Signature Date