

Precision Pain Management

4110 S 100th E Ave., Suite 201, Tulsa, OK 74146
P.918-857-7246 F.918-359-5828

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE)	AGE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY, STATE		ZIP CODE	HOME PHONE

I hereby authorize, Precision Pain Management to RELEASE or OBTAIN (Check one) Information and copies of records pertaining to my medical care and treatment.

I request my medical records ENTIRE CHART OTHER _____

RELEASE TO	DOCTOR/FACILITY/HOSPITAL NAME Precision Pain Management	<input checked="" type="checkbox"/>	PURPOSE OF REQUEST
	ADDRESS 4110 S 100th E Ave., Suite 201		Self, Employment or Other
	CITY, STATE, ZIP CODE Tulsa, OK 74146 Ph.918-857-7246 Fax 918-359-5828		Attorney
OBTAIN FROM	DOCTOR/FACILITY/HOSPITAL NAME		Insurance Company
	ADDRESS		Physician
	CITY, STATE, ZIP CODE		Disability

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH, OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.

I understand that if I am requesting records/information for release to me or patient representative:

- Laws may prevent certain records being released to the patient
- In certain situations, records denied for release to the patient may all patient to request and obtain a review of the denial

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This Authorization:

- Will expire in 12 months or on _____ (Date)
- May be revoked in writing care of the Medical Records Custodian, according to the Facility's Notice of Privacy Practices, but prior disclosures will not be affected
- Is not required for obtaining treatment or reimbursement for treatment, unless the sole purpose of this Authorization is to determine payment of a claim for benefits
- Is required for employment-related substance/alcohol screening

WARNING: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party.

Release: I release Precision Pain Management of Oklahoma listed above, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhoea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS) I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

SIGNATURE OF PATIENT	DATE
PERSON AUTHORIZED TO SIGN FOR PATIENT	DATE
RELATION SHIP TO PATIENT	