Patient Name:_____

Date of Birth:_____

MPC
MICHIGAN PAIN CONSULTANTS, PC

RELEASE OF RECORDS

Please print all information. Form must be signed and dated each year. **SSN last four digits:** _____

Entity Requested to Release Information: _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.
Who will be authorized to receive information (list the individual/entity that is to receive my PHI):

Individual/Entity Name_____Phone_____

Address: _____

_____

Description of information to be disclosed (select 1, 2, or 3 below) - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Please provide my 1 year history
- ☐ Please provide my entire record
- ☐ Please provide only the following for date range_____ to _____
  - ☐ Office notes
  - ☐ Lab reports
  - ☐ X-ray and MRI reports
  - ☐ Operative/Procedure reports
  - ☐ Physical therapy reports

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request ☐ Other (Please Specify):_____

- I approve, to the extent it exists in my records, the release of the following information: mental health (as addressed in 45CFR 164.501); alcohol abuse; substance abuse; AIDS; HIV; sexually transmitted diseases; rape and sexual abuse
- This authorization will expire 12 months after the date of my last signature below, unless I specify an earlier termination. I must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than 12 months_____
- I have the right to terminate this authorization at any time by submitting a written request to the Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- The practice has no control over the person(s) I have listed to receive my protected health information. Therefore, my protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient Signature date

_____ _____
Representative Signature date

_____ _____
Representative Printed Name date

You have the right to receive a copy of signed authorizations upon request.