Release of Records

SMPC
SOUTHERN MICHIGAN
PAIN CONSULTANTS

Patient Name: _____

Date of Birth: _____/_____/_____

Entity Requested to Release Information: _____
Address: _____
Phone: _____**Fax:** _____
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: *Southern Michigan Pain Consultants*
3770 Glenkerry Court, Portage, MI 49024
Phone: 269-266-3257 **Fax:** 866-942-6620

☐Please Provide 1 Year of Records

☐Please Provide the Following for date range _____ to _____.

☐Recent Office Note(s)- *(up to 3)*

☐Procedure and Surgical Notes

☐Diagnostic Imaging

☐Initial evaluation and discharge for physical therapy

☐Lab Reports

Purpose of Disclosure: ☐Patient Request ☐Continuation of Care

☐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:_____

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

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Entity Requested to Release Information –

This simply identifies who is to provide the information.

Purpose of Disclosure – Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Sensitive Information – This provides the ability to release all the information in your records

Expiration or Termination – This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate – You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement – This simply states that our practice does not place conditions for treatment on the use of the authorization.

Re-disclosure Statement – We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The re-disclosure statement simply informs you of this situation.

Signature and Date – We will need your signature and date of the signature to make the authorization effective.

Copies – We will provide you with a copy of this signed authorization upon request.