



*****PLEASE COMPLETE THIS FORM IF YOU WANT THE PRACTICE TO RELEASE YOUR MEDICAL INFORMATION TO A DESIGNATED FAMILY MEMBER*****

Authorization for Release of Protected Health Information

Patient Name: _____ Other Name: _____
Address: _____ Birth date: _____
_____ Soc. Sec. No.: _____
_____ Phone (Day): _____

I hereby authorize Apex Pain Specialists, P.C. to release medical information to:
NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP _____

For the following purposes (check one):

- At my request
- For _____

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I **do** **do not** authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

Patient or Personal Representative's Signature

Date

Description of Representative's Authority to Act for Patient