MEDICAL RELEASE FORM

PREMIER
PAIN MANAGEMENT
33 Electric Ave, Suite 102, Fitchburg, MA 01420
Phone: (978) 343-PAIN Fax: (978) 343-7247
www.premierpainfitchburg.com

Patient Demographic Information

Patient Name: _____

Date of Birth: _____**Social Security Number:** _____-_____-_____

Street Address: _____

City, State, and Zip Code:

_____

Phone Number: (_____) _____-_____

Sender

I authorize:

Name of Provider/Organization: _____

Street Address: _____

City, State, and Zip Code:

_____

Phone Number: (_____) _____-_____ **Fax Number:** (_____) _____-_____

Recipient

To share (disclose) my protected health information, including but not limited to the following: progress notes, procedure notes, urine and lab test results, personal identifying information, insurance and reimbursement information, imaging studies, and other diagnostic tests with:

Release to:

_____

PREMIER
PAIN MANAGEMENT
33 Electric Ave, Suite 102, Fitchburg, MA 01420
Phone: (978) 343-PAIN Fax: (978) 343-7247
www.premierpainfitchburg.com

The type and amount of information to be used or disclosed includes but is not limited to the entire medical chart, including complete medical records, history and physicals, office progress notes, hospital records, emergency reports, operative reports, procedural reports, physical therapy reports, pharmaceutical records, laboratory records, X-ray, MRI and CT scan films and results and other radiological films, and medical bills.

I understand that the information in my health records may also include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, pregnancy and/or family planning.

I authorize the release of my HIV test results. I have read this consent form and have had all my questions answered about the reason for release of my HIV tests results. I agree to the release of this information.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains the health insurance.

I hereby express my voluntary consent to disclose the above protected health information. I hereby release Premier Pain Management, PLLC from all liability that may arise from the release of these records.

I understand that any person or organization to which my records are disclosed may re-disclose this information.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of

PREMIER
PAIN MANAGEMENT

33 Electric Ave, Suite 102, Fitchburg, MA 01420
Phone: (978) 343-PAIN Fax: (978) 343-7247
www.premierpainfitchburg.com

information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signed: _____ **Date:** _____
(Patient, parent, guardian, patient representative)

Printed Name: _____

Witness: _____