Authorization to Release PHI

Authorization

Phone: 866-745-7246(PAIN) or 715-234-7246(PAIN) Fax: 715-234-7242	
Patient Information	
Name:	**Date of Birth:**
Address:	
City:	**State:**
Zip:	**Phone:**
Clinic/Hospital/Health Care Provider (Who has the information you want released)	
Name:	**Date of Birth:**
Address:	
City:	**State:**
Zip:	**Fax #:**
Receiving Party (where do you want the information to be sent/ or who may have)	
Name:	**Date of Birth:**
Address:	
City:	**State:**
Zip:	**Fax #:**
Information to be Released	
Please check all that apply: ❑ Pain Clinic Notes ❑ MRI/CT/Xray report ❑ Other Information	
If MRI/CT/Xray report, please specify	
If MRI/CT/Xray report would you like Mail CD	
If other, please specify	
Purpose for Release	
Please check all that apply: ❑ Insurance ❑ Continuing Care ❑ Legal ❑ Medical ❑ Other	
If other, please specify	
This authorization must be signed and dated. It may be revoked at any time according to IPSW, S.C. notice of Privacy Practice except to the extent action has been taken prior to the revocation. I understand that I may revoke this consent at any time, and that this authorization will automatically expire in twelve months (12) from the date of signing. I hereby stat that I have read and fully understand the above statements as they apply to me. I hereby consent to disclose of the medical records to the purpose and extent stated above. Once these records are released, this information is not protected by IPSW, S.C. and may potentially re disclosed by the party that received these records. I release IPSW, S.C., its employees, agents, directors, officers and affiliated from any liability that may be incurred by giving this information to the above.	
Patient Signature or Legally Authorized Representative	
If not signed by patient please specify Relationship to Patient	**Date:**