



HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: PAIN SOLUTIONS
8080 ACADEMY RD
SUITE A
ALBUQUERQUE, NM 87111

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, order sheets, progress notes, clinic records, treatment plans, admission records, requests for consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, and telephone messages.

All physical, occupational and rehab consultations and consultation requests.

All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

All pharmacy/prescription records

All billing records including itemized bills, and records of billing to third party payers a from _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

INITIALS: _____

This protected health information is disclosed for the following purposes: _____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Name of Representative

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

I understand the following:

- a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties.
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative

Date

Name and Relationship of Legally Authorized Representative to Patient

Witness Signature

Date