

**Carolinas Pain Institute, PA**  
**The Center for Clinical Research, LLC**  
145 Kimel Park Dr, Ste 330, Winston-Salem, NC 27103  
Phone: 336-765-6181 Fax: 336-765-8492

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

**Authorization for Use or Disclosure of Protected Health Information**

**I consent to and authorize:** \_\_\_\_\_  
(Person(s) or class of persons authorized to release the information)

\_\_\_\_\_  
(Address) (City, State, Zip)

**To release to:** \_\_\_\_\_  
(Person(s) or class of persons authorized to release the information)

\_\_\_\_\_  
(Address) (City, State, Zip)

<b>Description of information that may be used or disclosed:</b> <i>(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse and/or HIV/AIDS, if applicable)</i>
<input type="checkbox"/> Medical information from the most recent visit/admission to include physician notes/summaries and diagnostic results.
<input type="checkbox"/> Medical information including physician notes/summaries and diagnostic results for the periods from _____ to _____
<input type="checkbox"/> Other: Specific information to release _____ For the periods from _____ through _____
<b>The disclosed information will be used for the following purposes:</b>
Please specify the reason for the request, e.g. Treatment, insurance, legal, etc.
_____
_____
<input type="checkbox"/> At the request of the individual

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the Carolinas Pain Institute, PA: Office Manager. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the Carolinas Pain Institute Notice of Privacy. This authorization expires \_\_\_\_\_.

\_\_\_\_\_  
**Signature of Patient** or Personnel Representative (if applicable)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Requester's Home Phone/Work Phone

\_\_\_\_\_  
Authority to Act