Carolinas Pain Institute, PA

MEDICAL RECORDS RELEASE FORMS

PLEASE READ CAREFULLY, IF THIS FORM IS NOT FILLED OUT PROPERLY, WE WILL NOT BE ABLE TO RELEASE YOUR RECORDS.

Make sure you have your personal information listed at the top of the form.

- FULL name
- Date of Birth
- Social Security Number

I CONSENT TO AND AUTHORIZE:
PAY ATTENTION to who needs to release the information. If you are requesting records be released from our office, Carolinas Pain Institute – Our information needs to be filled in on the "I consent to and authorize:" line.

If you are requesting records be released from another provider (other doctor's office, Imaging office, Attorneys Office, etc.) to our office - Their information needs to be listed in the "I consent to and authorize:" line.

TO RELEASE TO:
If you are wanting these records released to yourself, make sure you have filled in the "TO RELEASE TO:" line with your personal information.
If you are wanting your information released to another office/provider, their information must be listed in the "TO RELEASE TO:" line.
If you are wanting records from another office released to Carolinas Pain Institute, our information needs to be in the "TO RELEASE TO:" line.

PLEASE NOTE:
When releasing information to other providers/offices: You MUST have accurate information. If you do not have this information with you, please take this release form home with you and get the information needed. We are NOT ALLOWED to write on this form for you, nor look this information up while you are here in the office.

Description of Information:
Please make sure you check what information can be released. If nothing is marked in this section, we will not release any records. If you, the patient, are wanting these records for yourself – make sure you select the "At the request of the individual" option.

At the bottom of the page, MAKE SURE you signed and dated the form.

Please double check that you have filled out this form out properly. AGAIN, if you have NOT filled this out, entirely – we will NOT be able to RELEASE your records.

Please allow at least 3 weeks for your records request to be completed. If you have any questions, please contact our Medical Records Coordinator, Debbie Bray, at 336-765-6181 ext. 190. Thank you.

Carolinas Pain Institute, PA
The Center for Clinical Research, LLC
145 Kimel Park Dr, Ste 330, Winston-Salem, NC 27103

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)

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