Referral Phone: 1-800-605-3418 **Referral Fax: 1-800-518-6271**
Huntersville Phone: 704-896-3313 **Huntersville Fax: 704-896-8193**
Statesville Phone: 704-278-4053 **Statesville Fax: 704-380-3150**
Shelby Phone: 704-481-0171 **Shelby Fax: 704-466-3342**

Authorization for Release of Protected Medical Records

Patient's Name____________________________________ Date of Birth___________________ Phone #______________________

Address____ City________________________________ State________ Zip__________

Release to: PAIN CLINIC OF North Carolina

To release from _____________________________________ Phone________________________ Fax________________________

Address____ City________________________________ State________ Zip__________

The purpose of this disclosure is: __ At the request of the individual __ Other_________________________________

The dates of patient care covered by this authorization are____

Release the Following Information

__ Discharge Summary __ Pathology Report(s) __ Emergency Record(s) __ History & Physical

__ Radiology Report(s) __ Itemized Billing Statement __ Consultation(s) __ Lab Report(s)

__ Operative Report(s) __ Cardiology Report(s) __ Progress Note(s) __ Treatment Plan(s)

__ Other Records as Specified____

__ Entire Medical Record (Except for Records Concerning Highly Confidential Information).

Release of Highly Confidential Information

By checking any of the boxes next to a category of Highly Confidential Information listed below. I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the line:
(*Please check all that apply – leaving a line unchecked may result in no information being disclosure for any purpose*).

__ Mental Illness of Developmental Disability

__ Sexually Transmitted Diseases (STD's)

__ Sexual Assault

__ Substance (i.e., alcohol or drugs) Abuse

__ Child Abuse and Neglect

__ Abuse of an Adult with a Disability

__ Genetic Testing

__ HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).

This Authorization Will Remain in Effect

__ From the date of this authorization until ____ (Not over one year)

__ Until the releasing entity fulfils the request or 120 days from the date this authorization is signed, whichever occurs earlier.

I understand that

- The information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may longer be protected by applicable federal and North Carolina law.
- I may refuse to sign this authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this authorization unless my treatment is research-related or I am to receive health care solely for the purpose of creating protected health information for disclosure to the recipient identified in this authorization.
- I have the right to revoke this authorization in writing at any time. The revocation will be effective immediately upon the Releasing Entity in reliance on this authorization before it received my written notice of revocation.

I have read and understand the terms of this authorization, and hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

____
Patient Signature (*Parent/Guardian if under age*)

____
Date/Time

____
Printed Name Patient/Parent/Guardian