Elite
PAIN MANAGEMENT
AND RECOVERY CENTERS

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
Release from Elite Pain Management and Recovery Centers

The authorization may be used to permit a covered entity to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

PATIENT INFORMATION:

Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

RELEASE FROM: (Please check clinic below) **FAX: 417-888-0189**

☐ 222 E. Primrose, Ste. E
Springfield, MO 65807
P: 417-888-0167

☐ 5780 Osage Beach Pkwy., Ste. 113
Osage Beach, MO 65065
P: 573-693-9080

☐ 1601 Kansas 66, Ste. C
Galena, KS 66739
P: 316-500-3180

☐ 8212 Devon Court
Myrtle Beach, SC 29572
P: 843-273-0376

☐ 7150 W. Sunset Rd., Ste. 202
Las Vegas, NV 89113
P: 702-514-1411

RELEASE TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

SPECIFIC INFORMATION TO BE DISCLOSED:

- ☐ Procedure summaries
- ☐ Urine drug screen results
- ☐ Billing and insurance
- ☐ Procedure images
- ☐ Medical record from (date) _____ to (date) _____
- ☐ Entire medical record including patient histories and office notes
- ☐ Other: _____

CONTINUED ON BACK SIDE

Elite
PAIN MANAGEMENT
AND RECOVERY CENTERS

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND COMMUNICABLE/ NON-COMMUNICABLE DISEASES

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse or treatment, psychiatric care, communicable and/or non-communicable diseases including but not limited to hepatitis, gonorrhea, syphilis and/or other sensitive information, I agree to its release. Check one: ☐ YES ☐ NO

HIV/ AIDS RECORDS RELEASE

I understand if my medical or billing record contains information in reference to HIV/ AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. Check one: ☐ YES ☐ NO

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on this authorization I can revoke this authorization to any time. Unless revoked, this authorization will expire on the following date or event _____ and not exceed one year from the date of signature. Indicating "any and all" records to be released will only specify records through the date the patient or patient representative signs this authorization as long as the authorization is not expired or revoked.

RIGHT TO REFUSE

I understand that I do not have to sign this Authorization, and my treatment or payment for services will not be denied if I do not sign.

I have read this form, understand, and agree to the uses and disclosures of information as described in this Authorization. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by State statute and/or 45 CFR § 164.502 (a)(1). I hereby knowingly and voluntarily authorize Elite Pain Management and Recovery Centers to use and disclose the protected health information specified above.

Patient/ Authorized Representative Signature: _____ Date: _____

Witness: _____ Date: _____