PUGET SOUND
PAIN CLINIC

Authorization to Release Information

Patient Name: (Please Print)	Date Of Birth	Social Security Number

PSPC MAY RELEASE MY INFORMATION TO:

Name:	
Address:	
Phone Number:	Fax Number:

PSPC MAY RECEIVE MY INFORMATION FROM:

Name:	
Address:	
Phone Number:	Fax Number:

INFORMATION TO BE RELEASED:

☐ The most recent 2 YEARS of Pertinent Information (Chart Notes, Lab Reports, Radiology, Special Tests, etc.)
☐ All Medical Records
☐ Specific Information (Please Specify):_____

Purpose for which information is being released (check one):

☐ Attorney ☐ Insurance Provider ☐ Personal ☐ Other (Please Specify):_____

This Authorization Will Expire On (Date or Specific Event): _____.
If no date/event is given, the authorization shall expire **90 DAYS** from the date signed. Possible copying fee required.

My Rights: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ DATE: _____
* If not listed on patient release of information medical records. Patient, Guardian, or Authorized Representative *Please provide documentation to prove authority to sign on behalf of the patient.