Authorization to Disclose Protected Health Information

The undersigned authorizes

Name/Facility: _____

Fax: _____

to release my health information as noted below:

*****All sections must be completed in order for request to be processed*****

Patient Information

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____ **Former Names?** _____

City: _____ **State:** _____ **Zip:** _____ **Phone #:** _____

Release Information To (THIS SECTION MUST BE COMPLETED)

****Please circle which Office or Department FAX number to send FAX too****

Crystal Coast Pain Management
2111 Neuse Blvd Ste. J
New Bern, NC 28560
PH: 252-636-0300
FAX: 252-636-0335

Crystal Coast Pain Management
5053 Executive Dr. Unit B
Morehead City, NC 28557
PH: 252-726-8480
FAX: 252-726-8638

Crystal Coast Pain Management
57 Office Park Dr.
Jacksonville, NC 28546
PH: 910-353-6008
FAX: 910-353-6009

Separate Department Fax Numbers:

New Patient/Referrals Dept.: FAX: 252-772-9994
Insurance Authorizations Dept.: FAX: 252-649-2977 (Tricare & BCBS only)
Insurance Authorizations Dept.: FAX: 252-565-0948 (Insurances "Except BCBS and Tricare")

Purpose of request: _____

Information to be Released (THIS SECTION MUST BE COMPLETED)

☐ **Office Notes** ☐ **Labs** ☐ **Operative Notes** ☐ **Diagnostic Reports** ☐ **Physical Therapy/ Chiropractic**

Specify "All" or Specific Date(s) of Service: _____

☐**Other** (Please Specify): _____

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ *(Please Initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____. If I do not specify expiration this authorization will expire in 1 year.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*: _____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*