Apex
PAIN SPECIALISTS

PLEASE COMPLETE THIS FORM IF YOU WANT THE PRACTICE TO RELEASE YOUR MEDICAL INFORMATION TO A DESIGNATED FAMILY MEMBER

Authorization for Release of Protected Health Information

Patient Name: _____ Other Name: _____
Address: _____ Birth date: _____
_____ Soc. Sec. No.: _____
_____ Phone (Day): _____

I hereby authorize Apex Pain Specialists, P.C. to release medical information to:
NAME _____ RELATIONSHIP_____

NAME _____ RELATIONSHIP_____

For the following purposes (check one):

☐ At my request
☐ For _____

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.
I ☐ **do** ☐ **do not** authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

_____ _____
Patient or Personal Representative's Signature Date

_____
Description of Representative's Authority to Act for Patient