



DISCLOSURE AUTHORIZATION FOR INFORMATION REQUESTS

(NOTE: This is the form to use for patient's authorization to obtain information from other health care providers.)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I, _____, hereby authorize the following providers:

(list all providers from whom information is being sought)

to disclose the following protected health information to Total Pain Care, LLC.

▶ PLEASE FAX RECORDS TO 601-482-9223 ◀

(check as applicable)

- Copies of EKGs taken within the past five years.
- Medical history, including specific progress notes regarding any problems that would impact my surgery or procedure's progress or outcome.
- A list of allergies.
- Results of relevant diagnostic or laboratory tests.
- Other: operative reports, EMG results

This protected health information is being used by the facility for the purpose of preparation for an outpatient procedure at Total Pain Care LLC.

This authorization will expire (Check ONLY ONE box):

- When I revoke this authorization
- Upon the following date, event or condition*: _____

I understand that, as set forth in the Facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Total Pain Care, LLC
1001 14th Street
Meridian, MS 39301
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that Total Pain Care, LLC has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and many no longer be protected by the federal or state law.

I understand that Total Pain Care, LLC will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have a right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

SSN Of Patient

Description of Personal Representative's Authority

DOB of Patient

▶ PLEASE FAX RECORDS TO 601-482-9223 ◀

(A copy of this signed authorization must be provided to the patient.)