S.E. PA
PAIN MANAGEMENT

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Limitations to information to be provided, please specify: _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____

Signature of Patient / Legal Guardian Date

_____

Relationship to Patient

_____

Signature of Witness Date

If patient is physically unable to provide a signature and desires to consent to the release, print his/her name & information in above form and record the signatures of two (2) responsible persons who witness that the patient understands the nature of this release and freely gave his/her consent

_____

Signature of Witness Date

_____

Signature of Witness Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED AND CAN BE REVOCABLE AT ANY TIME