AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name ____ Date of Birth: ________________________________

Address:____

City/State/Zip:____ Phone: ________________________________

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ____

Facility Address:____

City/State/Zip:____ Phone: ______________________________

Fax: _______________________________________ Email: ____

Dates and Types of Information to Disclose:

☐ 2 years prior from last dates seen
☐ Dates Other: _________________________
☐ Specific information requested:
  ☐ Progress notes
  ☐ Imaging
  ☐ Labs
  ☐ Procedure Notes

The purpose of disclosure is:

☐ Change of Insurance of Physician
  ☐ Continuation of Care (e.g., VA Med Ctr)
  ☐ Referral
  ☐ Other ___________________________________

Restrictions: Only medical records originated through healthcare facility will be copied unless otherwise requested. The authorization is valid only for the release of medical information dated prior to and including the date on this authorization form unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: Align Interventional Pain and Joint — Fax: **877.409.2879 (please fax records)**
Address: 3434 Houma Blvd; Suite 201, Metairie, LA 70006 — Phone: 504.547.7463

I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. This authorization will expire in 1 years if no other reason, condition, expiration date is given.
(Other expiration: ____________________________________)

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

____ ________________________________
Patient's Signature Date

____ ________________________________
Other Legally Responsible Signature Relationship to Patient and Phone Nu