Pain Care Consultants
Board Certified in Pain Medicine and Anesthesiology
Kathleen Majors, M.D. ♦ Ross B. Nelson, III, M.D.
Board Certified in Physical Medicine, Rehabilitaion & Pain Medicine
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Pain Care Consultants/Hunter Medical Systems, Inc. to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name: _____
Requestor Address: _____

Patient Name: _____
Patient DOB: _____
Patient Social Security Number: _____
Patient Address: _____
_____

Disclose the following PHI for treatment dates _____ to _____

☐ Abstract/Pertinent	☐ History & Physical	☐ Discharge Summary	☐ Consult
☐ Operative Report	☐ Progress Notes	☐ Physician Orders	☐ Nurse Notes
☐ ER Report	☐ Lab	☐ X-Ray	☐ Entire Chart

☐ Other Specified: _____
_____

The above information is disclosed for the following purposes:
☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.
Initials

This authorization shall expire upon this expiration date: _____
** If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Pain Care Consultants. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of Witness Date