HOT SPRINGS INTERVENTIONAL PAIN MANAGEMENT
ONE MERCY LANE SUITE 304 • HOT SPRINGS, AR 71913
(501) 321-4772 • Fax (501) 321-2945

Authorization for Release of Protected Health Information (PHI)

Name: _____ DOB: _____ Phone #: _____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ Fax: _____

PLEASE SEND INFORMATION TO:

Hot Springs Pain Management
Name of Provider/Clinic/Organization

One Mercy lane Suite 304
Street Address

Hot Springs AR, 71913
City, State, Zip Code

Phone: 501-624-7246 Fax: 501-321-2945

I AUTHORIZE the following information to be disclosed: (Please check all that apply)

- ____ Entire Medical Record
- ✓ Progress Notes
- ✓ Most Recent History & Physical
- ____ Consultations
- ____ Immunization Record
- ✓ Laboratory Reports
- ✓ Radiology/Imaging Reports/Films
- ____ Billing Records
- ____ Other _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

REASON for disclosure of health information: (Please check one)

- ☐ Continuing Care
- ☐ Consultation
- ☐ Second Opinion
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Personal Use
- ☐ SS/Disability (provide SSA letter)
- ☐ Job/School
- ☐ Other _____

EXPIRATION of this Authorization: (Please check one)

☐ 180 days after signature date ☐ On this date: _____ , ☐ After this event

This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Hot Springs Interventional Pain Management. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization as indicated in the above paragraph.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected by Hot Springs Interventional Pain Management.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____
Signature of Patient or Patient's Representative

_____
Date

_____
Printed Name of Patient or Patient's Representative

_____
Relationship to Patient or

_____
Legal Authority (attach supporting documentation)