The Pain and Headache Center, LLC

12835 Old Glenn Hwy Ste 2 Eagle River, AK 99577
907-622-3715 fax 907-622-3712

Authorization to release/receive records

I authorize The Pain and Headache Center, LLC, to _____release / _____obtain a copy of the medical information for:

PATIENT NAME: _____ DATE OF BIRTH: _____SSN:_____

Name of physician/clinic or Person_____
Phone: _____ Fax: _____
Address: _____ City, State, and Zip:_____

Information requested for the following purpose:

_____Continued treatment
_____Payment/billing
_____Second Opinion with:
_____ Personal Use
_____Legal Use
_____Employment
_____Other: (please specify)_____

By checking or initialing the spaces below I specifically authorize the use or disclosure of the following health information and/or records, as such information and/or records exist:

_____ Entire medical record (all information, including X-Ray images) **and/OR**
_____ Laboratory and/or Pathology reports
_____ Office chart notes
_____ Hospital surgery reports
_____ Diagnostic imaging/x-ray reports
_____ X-Ray images
_____ Billing statement/full account ledger
_____ Other: _____

_____I understand that 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/or drug abuse. I also understand it will not be released without my specific authorization.

_____ I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to The Pain and Headache Center, LLC I understand that this will not apply to information that has already been released as a result of this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***Unless otherwise revoked or specified below, this authorization will expire 6 months from the date it was completed.***

_____ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 184.524. ***I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may no longer be protected by federal confidentiality rules.*** If I have questions about disclosure of my health information I can contact The Pain and Headache Center, LLC

PLEASE NOTE: These are your copies. If you take them to another physician, a lawyer, etc., it is advisable that you make a copy for yourself first.

Signature of Patient or Representative: _____ Date: _____
Relationship to patient: _____
Witness: _____
Driver's License number or other I.D._____

*This authorization shall be in effect for **90 days** following the date of signature.*

FOR OFFICE USE ONLY:
Date Requested: _____ to be *Faxed Mailed Pick-up* Completed by: _____
Date Processed: _____ *Faxed Mailed Pick-up* Completed by: _____