PAIN CONSULTANTS OF SOUTH MISSISSIPPI
PAIN TREATMENT CENTER, LLC
Office Phone 601.268.8698
Fax 601.296.3049

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security#: _____ Telephone: _____

Information To be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please circle type of information to be released:

☐ Entire medical record ☐ History and physical exam ☐ Laboratory test results/reports
☐ Operative report ☐ Progress notes ☐ Consultation reports
☐ X-ray reports ☐ Emergency room record ☐ Discharge summary
☐ Other, (specify) _____

Person Authorized to Receive Information

Name: _____PAIN_TREATMENT_CENTER_____

Address: _____106_ASBURY CIRCLE_____

_____HATTIESBURG, MS_39402_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release, Circle One: YES or NO _____ initials.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Pain Consultants of So MS/Pain Treatment Center, Hattiesburg MS 39402. Unless revoked, this authorization will expire on the following date or even_____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May request Disclosure

I understand that Pain Consultants of South MS/ Pain Treatment Center may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Pain Consultants of So MS/ Pain Treatment Center to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Witness Signature: _____

Rev 08.08.18