ATLANTIC PAIN MANAGEMENT
& REHABILITATION, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____ Date of Birth: _____

MR#: _____ Social Security #: _____

Name & Address of Agency/Organization/Person Which Possesses Information To Be Released:

_____

_____

Name & Address of Agency/Organization/Person To Whom Information Is To Be Released:

_____

_____

Information Requested *(Specify the nature and extent of information to be released.)*

_____

_____

Purpose Or Need For Which The Information Is To Be Used:

_____

_____

I hereby request and authorize the above-named organization, or person which possesses information relative to the patient named above, to release information, as specified, to the organization, or person named on this request.

I understand that the information to be released may include information regarding HIV or AIDS status, drug abuse, alcohol abuse, or psychological or psychiatric impairments.

I certify that this authorization is made freely, voluntarily, and without coercion. I understand that the information to be released is protected under State and Federal laws and cannot be re-disclosed without my further consent, unless otherwise provided for by State and Federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

This consent will expire automatically after one year from the date on which it is signed, unless it is a blanket release to an insurance company for hospitalization benefits or for research purposes. A clear and legible photocopy of a consent for release information shall be considered to be as valid as the original.

_____ _____

Signature of Patient Legally Responsible Person

_____ _____

Signature of Witness Date

3210 North Croatan Highway, Suite 3 • Kill Devil Hills, NC 27948
Phone: 252/261-5868 • *Fax:* 252/441-7793