ADVANCED PAIN MEDICINE ASSOCIATES
Providing Hope for Pain Sufferers
3715 N. Oliver Street, Wichita, KS 67220 Tel. 316.942.4519 Fax 316.942.4655
JON C. PARKS M.D. GEORGE. G. FLUTER M.D.
Rita Simpson P.A. Lien Graham P.A. Linda Bayless ARNP

AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

Today's date:______________________

Patient name:___________________________________ DOB;______________ Social #:__________________________

1. I authorize the use or release/disclosure of the above named individual's health Information as described below.

2. The following individual or organization is authorized to make the release/disclosure to:

____
Provider name

____
Address Phone Fax

3. This information may be disclosed or release to the following individual or organization:

____

____

4. For the purpose of:____

5. The type and amount of this information is to be used or released/disclosed as follows:

□ Entire Record □ Accounting/Billing information □ Physical Therapy

□ Diagnostic/Imaging Reports:____________________ □ Lab Reports:______________________

□ Other [please specify]:____

6. 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/or treatment for alcohol and drug abuse.
________ Initial
7. I understand that treatment is not conditional upon the execution of this authorization. I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
8. I understand that fees may be charged for preparing and sending copies of records.
9. Advanced Pain Medicine Associates, P.A. is not responsible for completeness, legibility or omittance caused by the copying of any medical records from another institution.
10. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA compliance officer at Advanced Pain Medicine Associates. I understand revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 1 year from the date of Signature.

____ ______________________
Signature of patient or legal representative Date

____ ______________________
If signed by legal representative, relation to patient Date