

ADVANCED PAIN MEDICINE ASSOCIATES

Providing Hope for Pain Sufferers

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REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Today's date: _____

Please complete the following information:

1. Patients full legal name: _____
2. Patients social security number: _____
3. Patients date of birth: ____ / ____ / ____
4. Name of person submitting request [if other than the patient]: _____

Please describe the nature of your request: _____

Signature of patient/person representative: _____

FOR COVERED ENTITY USE ONLY:

Request has been: Accepted Denied

Signature of Privacy Official: _____

Date: _____