AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Innovative Injury Solutions

Phone: 480-573-0414 / Fax: 480-573-0413

Patient's name: _____ Date of Birth: _____

I request and authorize: _____ to release healthcare information of the patient named above to Innovative Injury Solutions:

PHONE: _____FAX: _____

Description of Protected Health Information to be disclosed:

☒ Last 3 office visit notes ☒All diagnostic reports ☒ Other: All procedure/surgical notes

Purpose(s) of the disclosure:

☒Continuity of Care ☐Transfer of Care ☐ Other: _____

I hereby authorize Provider to release Protected Health Information ("Information") to Innovative Pain and Wellness. I understand that this authorization may cover information relating to: (I) AIDS, HIV, and other communicable diseases; (II) genetic testing; (III) psychiatric, mental, and behavioral health and treatment; and (IV) alcohol, drug and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying the Provider in writing. I understand that any disclosure made pursuant to this authorization before, and revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eight (180) days following the date of execution. I understand that a photocopy of facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

_____ _____

Signature of Patient or Patients Legal Representative Date

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient:

_____

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