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.

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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: