Ohio Pain and Rehab Specialists
6651 Frank Ave. N.W.
N. Canton, OH 44720

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient: _____

Phone Number: _____

Address: _____

DOB; _____ **Age;** _____

Last 4 SSN: _____

I hereby give the following entity permission to release my Protect Health Information (PHI)

a. I instruct _____
Please state the Hospital or Doctor location/phone.

to release _____ to Ohio Pain & Rehab Specialist.
Please state what is being requested.

b. I instruct Ohio Pain & Rehab Specialists to release _____ to _____.

c. I am requesting my records be released to myself _____.

This authorization expires ninety (90) days from signature or at the following event:

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above are to be released through this authorization unless specified below:

DO NOT RELEASE: HIV- BEHAVIORAL HEALTH- DRUG/ALCOHOL-

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. the recipient of this protected health information is prohibited for re-disclosing the information unless the recipient obtains another Authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply me.

_____

Signature of Patient Date

_____

Signature of Parent/Guardian or Personal Representative (attach proper documentation)