CRESCENT Pain Relief

Patient Authorization to Release Medical Information

Patient Legal Name (Print)	Patient Social Security Number	Patient DOB
_____	_____	_____/_____/_____

_____ **(Initial)** I authorize *Crescent Pain Relief* and *Mohammed U. Shaikh, MD PA* to obtain or disclose my health information as described below.

Please identify the information to be obtained or released (check one option):

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests):_____
- ☐ Imaging reports (please describe the dates or types of images): _____
- ☐ Consultation reports (please provide doctors' names): _____
- ☐ Other (please describe): _____

The identified information will be used for the following purpose (check one option):

☐ My personal records - ☐ pick up in office ☐ mail to address on file *fee will be charged*

☐ Sharing with other health care providers as needed

☐ Other (please describe): _____

Please *initial* each item below to indicate your understanding.

_____ I understand 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 treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a 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 practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be obtained from the following doctor/hospital/clinic:

Name: _____ Name: _____

Fax Number: _____ Fax Number: _____

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____/_____/_____

Patient Signature (or Signature of Person Completing Form if Not Patient) Date

Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ _____/_____/_____

Office Staff Signature Date

Distribution of copies: original to practice, copy to patient, copy to accompany information released.

Phone (214) 310-0421