

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Send Information to: Center for Pain Medicine Phone: 330-971-7246

 Western Reserve Hospital Fax: **330-926-9432**

 1900 23rd Street

 Cuyahoga Falls, OH 44223 \*\*\***Attn: New Patient Coordinator\*\*\***

I hereby authorize  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  to release the health information to the recipient named above.

I understand that the information in my health record may include information relating to drug/alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C, acquired immunodeficiency (AIDS) or human immunodeficiency virus (HIV), or other sensitive information.

**INFORMATION TO BE RELEASED – CHECK ALL THAT APPLY:**

\_\_X\_\_ Pertinent Summary \_\_\_\_\_ Operative Report\* \_\_X\_\_ **X-rays\*/MRIs** \_\_\_\_\_ Discharge Summary\*

\_\_\_\_\_ History & Physical\* \_\_\_\_\_ Pathology Report\* \_\_\_\_\_Cardiology\* \_\_X\_\_ **Office Visit Notes**

\_\_X\_\_ **Consultation**\* \_\_\_\_\_ Lab Results\* \_\_\_\_\_ Emergency Record\*

\_\_X\_\_ Other: **Demographic sheet with patient’s insurance and contact information;** any **Discharge letters**

**DATES OF SERVICE: ALL dates of service pertaining to pain management evaluation and treatment**

**PURPOSE or NEED FOR INFORMATION:** Continuity of Care

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Dept. Director. I understand that the revocation will not apply to information that has already been released in response to this authorization.

* This authorization for access or release is valide for 1 (ONE) YEAR from the date of the signature.
* By law, you have 30 days to provide copies of records to the above recipient..

AUTHORIZAING SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signed by: \_\_\_\_ Patient; \_\_\_\_\_ Legal Guardian; \_\_\_\_\_ Executor of Estate; \_\_\_\_\_ Other (Specify)

I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal privacy laws and regulations. Rev04.03

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 westernreservehospital.org

