Elite Pain Center, LLC
186 South Macon Street
Jesup, GA 31545
912.530.7516
Fax: 912.559.6191

Patient Name: ______________________________

DOB: ______________ SS# __________________

Authorization for Use or Disclosure of Protected Health Information

I consent to and authorize: ____
(Person(s) or class of persons authorized to release the information)

____
(Address) (City, State, Zip)

To release to:. ____
(Person(s) or class of persons authorized to release the information)

____
(Address) (City, State, Zip)

Description of information may that may be used or disclosed:
(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse and/or HIV/AIDS, if applicable)

____Medical information from the most recent visit/admission to include physician notes/summaries and diagnostic results.
____Medical information including physician notes/summaries and diagnostic results for the periods from __________ to ______.
____Other: Specific information to release ______________________________
For the periods from __________________ Through ______________________________

The information will be used disclosed for the following purposes:

Please specify the reason for the request, e.g. Treatment, insurance, legal, etc.

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_____ At the request of the individual

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the Elite Pain Center, LLC Clinic Administrator. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the Carolinas Pain Institute Notice of Privacy. This authorization expires ______________________

______________________________ ______________________
Signature of Patient or Personnel Representative (if applicable) **Date**

______________________________ ______________________
Relationship to Patient Requester's Home Phone/Work Phone

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Authority to Act