Advanced Pain Treatment Center
INNOVATIVE HELP FOR MANAGING YOUR PAIN

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CONSENT AND AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Forms

I, _____, DOB_____, consent to and authorize the Advanced Pain Treatment Center to furnish to:

_____

_____
(Person or facility, address, city, state, and zip)

the following medical records information:

_____
(Specify patient name, admission date or permission concerned)

_____**EXCEPT** those relating to care and treatment for mental health conditions, drug or alcohol abuse, or HIV testing, infection status, or care and treatment for AIDS, or genetic testing. (initial)

_____**INCLUDING** the following: (initial)

- Relating to care and treatment for mental health conditions
- Relating to care and treatment for drug or alcohol abuse
- Relating to HIV testing, infection status, or care and treatment for AIDS
- Relating to genetic testing

For the purpose of _____
(Reason for disclosure)

I understand this consent and authorization may be revoked at any time except to the extent already acted upon. This consent and authorization expires on (1) year of the date signed. A photostatic copy of this consent shall be consent shall be considered as effective and valid as the original

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Par2). The Federal rules and Kentucky law and Ohio law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertain to (42CFR Part 2or Section 191.656). A general authorization for the release of medication or other information is NOT efficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.