ALGONE DFW
INTERVENTIONAL PAIN

5860 Collin McKinney Parkway, Suite 604, McKinney, TX 75070

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I understand the following:

- **The following form must be completed in its entirety to ensure request fulfillment. Please address all areas as appliable to your request.**
- **Minors: A minor patient's signature is required to release the following information; Conditions related to, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (14 years or older), and/or Substance Abuse diagnosis or treatment and mental health conditions (13 years or older).**
- **Patient Rights:**
  - **By signing this authorization form, I am demonstrating that I have read and understand the following information: Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. I understand that my substance use disorder records are protected under the Federal regulations governing confidentiality and substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent, unless otherwise provided for by the regulations.**
  - **I understand that the information used or disclosed may be subject to re-disclosure by the person or class or persons or facility receiving it and would then no longer be protected by federal privacy regulations.**
  - **I must sign an authorization form to take part in a research study or to receive healthcare when the purpose is to create health information for a third party.**
  - **I may revoke this authorization at anytime in writing. If revoked, it would not affect any actions already taken by Algone DFW based upon this authorization. I may not be able to revoke this authorization if its purpose were to obtain insurance. Ways to revoke this authorization are: Fill out a revocation form (available from the office) or write a letter to the office stating that you want to revoke this form.**
  - **You may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.**
- **Records received from another source cannot be given to you. We advise that you always keep your own copy for future needs.**

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I authorize Algone Anchorage to use and disclose a copy of the specific health information described below regarding:

Patient Name: _____ **Date of Birth:** _____
Last First M.I

Address: _____

Phone: (_____)_____ **Email:** _____

To be disclosed to: □Self □Or Recipient's Name: _____

Recipient's Address:_____
Street City, State Zip

Phone: _____ **Fax:** _____

Please send my records via: □ **Mail** □ **Fax**

I am requesting my information from the following Facility(s): List Hospital/Clinic/Provider Name

I authorize the following to be released from my medical records:

□Last 6 months □Last year □Entire medical record
□Date range (please specify) To: _____ **From:** _____
□Information related to the following Diagnosis or Injury: _____

For the purpose of: _____

Unless revoked, this authorization expires in 180 days or on this date: _____

I understand that the following sensitive/confidential information below will be disclosed if I initial in the applicable spaces next to the information type.

_____ **HIV/AIDS testing/treatment**	_____**Sexually transmitted disease or testing records**
_____ **Alcohol/Substance Abuse Records**	_____ **Mental Health Records**
_____ **Genetic Records**	_____**Genetic Records**

Patient Signature: _____ **Date:** _____

Representative Name: (print) _____ **Relationship:** _____

Representative Signature: _____ **Date:** _____