Interventional PAIN CARE, LLC

Authorization to Release Medical Records

Records to be released from Interventional Pain Care, LLC
PO Box 1736
Muncie, IN 47308

I hereby request and authorize the above provider to furnish records for the purpose of

_____ or at my request.

Records to be sent to:
Provide complete name,
address, and zip code _____

_____

_____

Patient Information

Patient Name _____ Phone _____
Address _____ DOB _____
City, State, Zip _____ SS# _____

Information that may be released:

___ All records ___ Office Visit Notes ___ Prescription
___ Labs ___ History & Physical ___ Consultation report(s)
___ Therapy notes ___ Discharge Summaries ___ Image reports (MRI, x-ray, etc.)
___ Operative Reports ___ Other _____

___ I understand that this release also pertains to records regarding drug and alcohol treatment, mental health records, and communicable disease records, including HIV and AIDS.

Limitations: Do not release information in my record regarding _____.

Release my records only for dates of _____ through _____.

I understand that (1) I may revoke this authorization at any time in writing, except to the extent that authorization has been taken based upon it; (2) that the recipient of these records may further disclose the information because of this authorization and it may then no longer be protected by Federal Privacy Regulations; (3) I am entitled to ask for a copy of this document; (4) I may refused to sign this authorization and my refusal to sign will not affect my ability to obtain treatment. There may be a discharge for the release of these records pursuant to Indiana Code 16-39-9-3 and CPR 164.524 (HIPAA).

Signature of patient or patient representative _____

Description of representative's authority to act for patient _____

Date signed _____ Expiration: 60 days or earlier date of _____

Authorizations for health records as defined by Indiana Statute may not be effective for longer than 60 days.