APM Fax: 678-214-3051

Mail to:
Advanced Pain Management ROI
PO Box 19051
Green Bay, WI 54307

Authorization for Disclosure of Protected Health Information

ADVANCED PAIN MANAGEMENT

Instructions: Fill out form in its entirety. We need all of the information on this form in order to process your request.

If you would like your records to be disclosed to more than one individual or entity, please complete a separate form for each individual or entity to whom you would like your records disclosed.

Patient Name: _____ **Date of Birth:** _____

Address (including City/State/ZIP) _____

Phone Number: _____

Maiden/Previous Name/Nicknames: _____

Release Information From:	**Release Information To:**
Provider/Facility Name:	**Name/Facility:**
Address:	**Address:**
City/State/ZIP:	**City/State/ZIP:**
Phone:	**Phone:**
Fax #	**Fax #** ***(for provider use only):***

Purpose of Release:

☐ Continuing Care ☐ Personal ☐ Transfer of Care ☐ Disability Determination
☐ Legal ☐ Work Comp ☐ Insurance ☐ Other: _____

Information to be Released:

Release Method: ☐ Mail ☐ Fax _____

Service Dates: From _____ To _____

☐ Operative/Procedure Notes ☐ Laboratory Reports ☐ Other (Please specify)
☐ Office Visit Notes ☐ Radiology Reports _____
☐ Billing Statements ☐ Entire Medical Record *(Notes/reports produced and/or ordered by APM providers only)*

I do not want the following information disclosed (as defined by applicable state and federal laws):

☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AIDS ☐ Alcohol/Drug Abuse ☐ Genetic Information

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Refuse to Sign This Authorization. I understand that I have the right to refuse to sign this Authorization and APM will not condition treatment or payment upon my signing of this Authorization.

Right to Revoke Authorization. I understand that I have the right to revoke this Authorization, except to the extent that APM has already disclosed my medical information in reliance of this Authorization. I understand that my revocation is effective only if it is in writing. To revoke my Authorization, I understand that I must send a written request for revocation to APM's corporate medical records staff, Attn: Medical Records Supervisor.

Re-disclosure of Information by Recipient. I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person(s)/organization(s) receiving my medical information and no longer protected by applicable privacy laws.

Right to Receive a Copy of This Authorization and My Medical Information. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I also have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization.

By signing this form, I am authorizing Advanced Pain Management and its affiliates and subsidiaries ("APM") to disclose my medical information as described in this Authorization.

Signature *(required)*:	**Date Signed** *(required)*:
Printed Name of Person Signing (if not patient):	

Patient Is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Activated Power of Attorney ☐ Next of Kin