Patient Information: I give permission to release the health information of:

Patient Name: ____ Date of Birth: ____________________________
Street Address: ____ Last 4 numbers of SSN:_____________________
City, State, Zip: ____ Telephone: ( ) ____________________________
Email address: ____

Release Information From:	**Release Information To:**
____	____**Pain Management Plus, PLLC**_______
(Name of facility, person, company)	_ __**249 Oak St_Forest City, NC 28043**____
____	____**Ph: 828-919-2393**________________
(Street Address or PO Box, City, State, Zip Code)	
____	
(Phone number) (Fax number)	**__FAX RECORDS TO: _888-284-2932__**

PURPOSE OF RELEASE (check reason):

- ✓ Continued patient care
- ✓ Transfer of patient care

Fill in dates of treatment for records to be released:

- ✓ ALL DATES

Medical Office/Facility (check all that may apply):

- ✓ Entire record
- ✓ Progress Notes, including mental health therapy notes
- ✓ Laboratory reports
- ✓ Radiology/X-Ray Reports
- ✓ Any and all referring/consulting records on file from other providers and practices

FORMAT:	**DELIVERY METHOD REQUESTED:**
✓ Paper	✓ **Fax**

PATIENT'S RIGHTS – I understand that:

♣ I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.

♣ This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.

♣ Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.

♣ Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.

♣ The practice will not share or use my health information without my permission other than by ways listed by the Notice of Privacy Practices or as required by law.

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

- ☐Healthcare Agent/POA
- ☐Guardian
- ☐Executor/Administrator/Attorney in Fact
- ☐Spouse
- ☐Parent
- ☐Adult Child
- ☐Affidavit Next of Kin
- ☐Other: _________________________________

This permission expires 12 months after the date of my signature

Signature: _____________________________ Print Name: _______________________________Date:______________

Employee handling request: _________________________ Date: ______________