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Authorization To Review/Release Or Obtain Medical Information

Patient Name:_____ Date of Birth:_____

( ) I hereby authorize Shoreline Interventional Pain Center (SIPC) to review/release information to: (person or agency, address, city, state & zip)

_____

_____

_____

( ) I hereby authorize Shoreline Interventional Pain Center (SIPC) to obtain information from: (person or agency, address, city, state & zip)

_____

_____

_____

Date(s) of service:_____ Use of formation:_____

Check each type of information that you are authorizing to be release:

( ) medical/ surgical

( ) psychiatric, drug abuse and/or alcohol abuse

( ) AIDS and/or HIV related information

( ) Release ALL Information

( ) Release ONLY SPECIFIC Information

- ( ) Summary of Treatment
- ( ) Clinical Progress Notes
- ( ) Special Procedures
- ( ) Consultation Report
- ( ) Lab Report
- ( ) other:_____

In the event that any of the information to be released constitutes psychiatric communication and records which may be released only with written consent, I understand that my refusal to grant such consent will in no way jeopardize the patient's right to continue to obtain except where disclosure is necessary for treatment.

In the even that any of the information to be released relates to treatment for alcohol or drug use, I understand that such information is subject to the Code of Federal Regulations which prohibits the further release of such information unless consent is granted in accordance with such regulations or is not required by such regulations.

In the event that the information released constitutes confidential HIV/AIDS related information I understand the state law prohibits further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Guardian Name:_____