Advanced Interventional
Pain Management, PA

160 Kimel Forest Drive, Suite 100
Winston-Salem, NC 27103

Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____
Please print full name

1. I authorize the use or disclosure of the above named individual's health information by _____ as described below.

2. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where needed)

☐ Clinic Note	☐ Progress Note	☐ Anesthesia/Sedation Record
☐ Nurse's Note	☐ Prescription History	☐ Consultation Note
☐ Laboratory Result	☐ Radiology Result	☐ Operative/Procedure Report
☐ History and Physical Report	☐ Urine/Blood Screen Results	

☐ Other: _____

The above information can be released for the period of _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

4. The information identified above may be used or disclosed to the following individual(s) or organization(s):

Advanced Interventional Pain Management, PA
Drs. Faller and Meloy
160 Kimel Forest Drive, Suite 100
Winston-Salem, NC 27103
Phone (336) 714-6400
Fax (336) 714-6402

5. This information for which I am authorizing disclosure will be used for the following purpose:
☐ sharing with other health care providers
☐ other: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization will expire on _____. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

8. I understand that once the above information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations.

9. I understand the use or disclosure of the information identified is voluntary. I need not sign this form to ensure access to medical treatment.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date