INTERVENTIONAL PAIN INSTITUTE
Diagnosis & Treatment of Spine, Cancer and Chronic Pain

8017 Picardy Ave Baton Rouge, LA 70809 Phone: 225-769-3636 Fax: 225-771-8047

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Address: _____

Please Note: Copy Fee May Be Charged For Medical Records

Medical Records. I hereby authorize ("Releasor") to or disclose the following: (check one)

☐ -ALL Medical Records . I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

☐ - Restrictions - Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

- ☐ - Be Included.
- ☐ -NOT Be Included.

☐ - Specific Medical Records : _____

My medical records shall be disclosed to the following individual or entity:

Name: Interventional Pain Institute, LLC. E-Mail: info@ipipain.com

Address: 8017 Picardy Ave Baton Rouge, LA 70809

Phone: 225-769-3636 Fax: 225-771-8049

Expiration. This authorization expires on: _____

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization. I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Printed Name Relationship to Patient