METRO PAIN ASSOCIATES

400 Executive Park • Louisville, Kentucky 40207 • Telephone (502) 896-9877 • Fax (502) 896-9972

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name:	Release To:
Date of Birth:	
Social Security #:	

AUTHORIZATION

I Hereby authorize

_____

to examine and/or receive a copy of medical records pertaining to Medical History. Mental or Physical Condition, Service Rendered, or Treatment (including but not limited to records of Drug and/or Alcohol Abuse or Psychiatric Treatment, HIV Testing and/or/ AIDS/ARC diagnosis and/or related conditions.

USES

☐ CONTINUITY OF PATIENT CARE

☐ OTHER (Specify):_____

INFORMATION REQUESTED

SERVICE TYPE	DATE(S)	TYPE OF INFORMATION
☐ INPATIENT	_____	_____
☐ OUTPATIENT	_____	_____
☐ EMERGENCY	_____	_____
☐ OTHER	_____	_____

DURATION

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire _____ from the date of signature.

RESTRICTIONS

Any disclosure of medical information by the recipient(s) is prohibited by law except when implicit in the purposes of this disclosure or unless a valid authorization is obtained.

Patient's Signature:	Date:

RELATIONSHIP (if other than patient)

☐ Executor of Estate ☐ Next of Kin

☐ Legal Guardian ☐ Parent

☐ Witness ☐ Other

Signature:	Date: