

Advanced Interventional Pain & Sports Medicine Center

20 Crossroads Dr, Ste 210 , Owings Mills, MD 21117
Tel: (410) 581 2969 Fax: (410) 581 5775

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____XXXXXXXXXXXXXXXXXXXX

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
____Amit Bhargava, MD, MS, RMSK_____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

Name

Address

City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *X_____

NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. My purpose/use of the information is for _____.

7. This authorization expires on _____, 201____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

X _____
Signature of Individual* **Date of Individual's Signature** **Date of Birth or Social Security Number**
(The person about whom the information relates)
OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate **Date of Guardian's/Personal Representative's Signature** **Description of Authority to Act for the Individual**
A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

Received

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