

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's name: _____ Date of Birth: _____

I request and authorize **Adam Wuollet, MD**, to disclose healthcare information regarding the above named patient to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Description of Protected Health Information to be disclosed:

Complete Medical Record Urine Drug Screens Lab Tests

All diagnostic reports (EMG, CT, MRI, X-ray etc) Other: _____

Purpose(s) of the disclosure:

Continuity of Care Transfer of Care Personal Use

Second Opinion Supplemental Care Legal

Insurance Coverage or Payment of Care Other: _____

I hereby authorize Provider to release Protected Health Information ("Information") to Innovative Pain and Wellness. I understand that this authorization may cover information relating to: (i) AIDS, HIV and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental and behavioral health and treatment; and (iv) alcohol, drug and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before and revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eight (180) days following the date of execution. I understand that a photocopy of facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

Signature of Patient or Patients Legal Representative

Date

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.