THE CENTER *for* PHYSICAL
MEDICINE & PAIN MANAGEMENT
RACHELLE JANUSH, D.O.

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Montgomery, Alabama 36117
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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Physician / Pharmacy / Facility Releasing Medical Information:_____

Fax # _____ Phone # _____

Patient Name: _____ Date of Birth: _____
Address: _____

Note: "You" refers to the person to whom this authorization is directed. "I, "me" or "my" refers to the patient.

AUTHORIZATION

_____ **You are hereby authorized to disclose the following Protected Health Information to the above physician and/or healthcare facility.**

- ❑ **Most recent office notes**
- ❑ **Most recent labs & x-rays**
- ❑ **Current medication list**
- ❑ **Most recent hospital records**
- ❑ **Most recent hospital labs & x-rays**
- ❑ _____

_____ **You are hereby authorized to disclose my Protected Health Information to the above physician and/or healthcare facility specifically pertaining to my** mental health, including but not limited to: psychiatric and psychological information, drug and alcohol abuse treatment information, and information related to HIV and/or hepatitis.

PATIENT'S RIGHTS

I understand I do not have to sign this authorization to receive health care benefits (treatment, payment or enrollment) from the person(s) to whom this authorization is directed. I may revoke this authorization in writing at any time. If I do so, it would not affect any actions already taken by someone in reliance on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance coverage. If I wish to revoke this authorization, I shall do so by sending a letter to the person(s) to whom this authorization is directed. Once the health care provider discloses health information, any person or organization that receives it may re-disclose it. In the event that a breach of unsecured protected health information occurs we (and our Business Associates) are required to make certain notifications, such notifications include the affected individual, Dept. of HHS and in certain circumstances, the media. Patient privacy laws may no longer protect that information. I must sign an authorization form to take part in a research study, marketing and fundraising opportunities or to receive health care when the purpose is to create health information for a third party.

_____ _____ _____
Patient or Legally Authorized Individual Signature *Date* *Time*

_____ _____
Printed Name (If signed on Behalf of Patient) *Relationship (Parent, Legal Guardian, etc.)*

This authorization shall expire one year from the date indicated above.