TRANSCEND
HEADACHE CLINIC

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Authorization for Disclosure of Protected Health information

Instructions: Fill out each section of the form in its entirety. You may mail, fax, email or hand deliver this release when completed to the address or fax listed. Failure to do so may delay in processing of your request.

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Full Address: _____

Patient Contact Phone Number: _____

Maiden/Previous Names: _____

RELEASE OF INFORMATION FROM

Name/Facility: _____

Full Address: _____

Phone: _____

RELEASE OF INFORMATION TO

Name/Facility: _____

Full Address: _____

Phone: _____

PURPOSE OF RELEASE

☐ Continuing Medical Care ☐ Application for Insurance ☐ Worker's Comp
☐ Insurance Claim ☐ Disability Determination ☐ Personal
☐ Other:_____

If you have a preferred provider at our clinic, please list:_____

INFORMATION TO BE RELEASED

☐ Complete Medical Record ☐ ER Reports ☐ Medications
☐ History & Physical ☐ Alcohol/Drug Treatment Records ☐ Consultations
☐ Procedure Reports ☐ Lab/Pathology Reports ☐ Immunizations
☐ Imaging Reports/Images ☐ Psychological Eval/Assmts ☐ Final Diagnosis
☐ Admit/Discharge Summaries ☐ EKG & Cardiology Reports ☐ Other:_____

NOTE: This authorization expires form one year from the date of my signature unless I specify a different event, purpose, or alternative, expiration date here: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

☐ Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release of Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature: _____Date: _____

Printed Name of Person Signing (if not patient): _____

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