ODYSSEY PAIN CENTER

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: ____

(First Name) (Middle Initial) (Last Name)

Address: ____

Date of Birth: ____

ODYSSEY PAIN CENTER is authorized to **furnish to / receive from**:

Recipient/Discloser: ____

For the Purpose of : ____
(optional)

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- ❑ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

Kindly provide the following documents for this patient (if any):

1. Physician's notes: for the last 6 months including Primary Care Physician, Rheumatology, Pain management, Neurology, Orthopedic surgery, neurosurgery consultations and hospitalization discharge summaries.

2. Imaging reports: MRIs, CT scans and/or XRAYs

3. Labs: Urine drug testing/CBC/CHEM 7/COAGULATION

4. Other studies: Electromyography(EMG)/Nerve conduction study(NCS) etc…

Please be aware that this patient may not be scheduled at Odyssey Pain Center until this information has been received.

I release ODYSSEY PAIN CENTER., the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to ODYSSEY PAIN CENTER provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

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Patient Signature (Parent's Representative if minor) Date