

**Authorization Form
for Release of Information
for Interventional Pain Care, LLC**

By signing this form, you are authorizing this practice to release all or part of your Private Health Information (PHI). Please read this document carefully.

The following statement describes the information to be used or disclosed:

Interventional Pain Care, LLC, is authorized to use or disclose this information to

This authorization expires _____.

You have the right to revoke this authorization by submitting a written request for revocation of authorization, including the date of original authorization and other pertinent details needed for processing your request. This written revocation must be made to the Practice Manager. The Practice Manager will be unable to process your request if it is made after the PHI has already been disclosed and if sufficient details are not given about the original authorization in order to process the request. The information you authorize this practice to disclose may be subject to re-disclosure by the recipient; if so, the information may no longer be covered by your revocation.

By signing this document, you indicate that you have read and understood the information put forth and that you are authorizing the release of the PHI outlined above to the person or class of persons listed.

Signature of Patient or Authorized Representative

Date

Name of Patient (please print)

If this document was signed by a personal representative of the patient, a description of the representative's authority to act for the patient must be provided.