

STATEMENT FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient: _____
Address: _____

Phone #: _____
Date of Birth: _____
SS #: _____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure (from):

Name: _____
Address: _____

Phone #: _____
Fax #: _____

3. Information Requested:

- Complete Health Records Physical Exam Lab results
 Diagnostic Reports Office Notes Consult Reports
 Other (please specify): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization (to):

Name: Pars Interventional Pain & Wellness Center
Peter Pantelidis, MD & Gregory D'Eramo, MD
Address: 1212 Garfield Ave., Suite 202
Parkersburg, WV 26101

Phone #: 304-865-7277
Fax #: 304-865-7273

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the clinical manager. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
7. If I fail to specify an expiration date, event, or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative

Signature of Witness

Date