

RELEASE OF INFORMATION FORM



Please complete the form legibly and in its entirety. Incomplete forms may result in delay or denial of this request.	
PATIENT INFORMATION	Patient Name: _____ Date of Birth: _____
	Address (City, State, Zip Code): _____
	Phone Number: _____ Email: _____
	Previous Name(s)/Nickname(s): _____
RELEASE MY RECORDS FROM	Check One Option Only <input type="checkbox"/> Capitol Pain Institute (Clinic) <input type="checkbox"/> Center for Specialty Surgery (ASC) <input type="checkbox"/> Both Clinic & ASC <input type="checkbox"/> External/Outside Organization (Complete Below)
	Organization Name: _____ Fax: _____
	Address (City, State, Zip Code): _____
	Phone Number: _____ Email: _____
RELEASE MY RECORDS TO	Check One Option Only <input type="checkbox"/> Capitol Pain Institute (Clinic) <input type="checkbox"/> Center for Specialty Surgery (ASC) <input type="checkbox"/> Both Clinic & ASC <input type="checkbox"/> External/Outside Organization (Complete Below)
	Organization Name: _____ Fax: _____
	Address (City, State, Zip Code): _____
	Phone Number: _____ Email: _____
INFORMATION TO BE RELEASED	<input type="checkbox"/> Specific Date of Treatment: _____ Area of Pain: _____ <input type="checkbox"/> Last 3-5 Visit Notes <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Billing Statements <input type="checkbox"/> Physical Therapy Notes <input type="checkbox"/> Operative/Procedure Notes <input type="checkbox"/> Behavioral Health Evaluations <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Other (please specify): _____
	Special Permission is Required to Release the Following Records and may Require a Separate Form
	<input type="checkbox"/> Psychotherapy Notes <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Reproductive Health
	<input type="checkbox"/> Personal <input type="checkbox"/> Continuing Care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Disability Determination <input type="checkbox"/> Legal <input type="checkbox"/> Workman's Compensation <input type="checkbox"/> Insurance <input type="checkbox"/> Other
PURPOSE OF REQUEST	
RELEASE METHOD	<input type="checkbox"/> Mail <input type="checkbox"/> Pick up LOCATION: _____ DATE/TIME: _____ <input type="checkbox"/> Fax: _____ <input type="checkbox"/> Secure Email: _____

I understand that I have the right to refuse this Authorization, and CPIhealth will not condition treatment or payment upon my signing of this Authorization. I understand that I have the right to revoke this Authorization, except to the extent that CPIhealth has already disclosed my medical information in reliance of the Authorization. Revocation is only effective in writing and must be sent via a written request to CPIhealth's corporate medical records staff. I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person/organization receiving my medical information and no longer protected by law. This Authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

By signing this form, I authorize CPIhealth and its affiliates and subsidiaries to disclose my medical information as described in this Authorization.

Date	Signature	Patient/Legal Guardian
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