RELEASE OF INFORMATION FORM

CPIhealth

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 All that Apply** ☐ Capitol Pain Institute (Clinic) ☐ Center for Specialty Surgery (ASC) ☐ Waterleaf Surgery Center (WLSC) ☐ External/Outside Organization (Complete Below)	
	Organization Name:	Fax:
	Address (City, State, Zip Code):	
	Phone Number:	Email:
RELEASE MY RECORDS TO	**Check All that Apply** ☐ Capitol Pain Institute (Clinic) ☐ Center for Specialty Surgery (ASC) ☐ Waterleaf Surgery Center (WLSC) ☐ External/Outside Organization (Complete Below)	
	Organization Name:	Fax:
	Address (City, State, Zip Code):	
	Phone Number:	Email:
INFORMATION TO BE RELEASED	☐ Specific Date of Treatment:	Area of Pain:
	☐ Last 3-5 Visit Notes ☐ Office Visit Notes ☐ Laboratory Reports ☐ Billing Statements ☐ Physical Therapy Notes ☐ Operative/Procedure Notes ☐ Behavioral Health Evaluations ☐ Radiology Reports ☐ Other (please specify):	
	Special Permission is Required to Release the Following Records and may Require a Separate Form	
	☐ Psychotherapy Notes ☐ Chemical Dependency ☐ Substance Use Disorder ☐ Reproductive Health	
PURPOSE OF REQUEST	☐ Personal ☐ Continuing Care ☐ Transfer of Care ☐ Disability Determination ☐ Legal ☐ Workman's Compensation ☐ Insurance ☐ Other	
RELEASE METHOD	☐ Mail ☐ Pick up LOCATION: _____ DATE/TIME: _____ ☐ Fax: _____ ☐ 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**