



# Javery Pain Institute

https://javerypain.com



Patient Information:	Name: _____ Date of Birth: _____	Maiden Name/Alias: _____ Phone: _____
<b>Health Information Released FROM:</b> <input type="checkbox"/> Javery Pain Institute <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ Email: _____ Fax: _____ Phone: _____		<b>Health Information Released TO:</b> <input type="checkbox"/> Javery Pain Institute <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ Email: _____ Fax: _____ Phone: _____
Health Information to be <b>RELEASED:</b>	Date(s) of Treatment Received: _____ (If dates not specified, only the most recent year will be released) <input type="checkbox"/> Progress Notes <input type="checkbox"/> Diagnostic Reports <input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Procedure Notes <input type="checkbox"/> Other: _____ <b>All information regarding chemical dependency treatment, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:</b> ___ Do Not Release Chemical Dependency Treatment records ___ Do Not Release Mental Health records ___ Do Not Release HIV/AIDS records <b>___ By initialing here I give consent for Javery Pain Institute to verbally communicate with the listed authorized recipient.</b>	
Purpose of Release:	<input type="checkbox"/> Personal <input type="checkbox"/> Attorney <input type="checkbox"/> <b>Continued Care - Appt Date:</b> _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/ Social Security <input type="checkbox"/> Other: _____ <input type="checkbox"/> Transfer from Practice/Reason? _____ <p style="text-align: center;"><b>There may be a charge/fee for copies of records</b></p>	
Delivery Method:	<input type="checkbox"/> <b>Mail</b> <input type="checkbox"/> <b>Fax</b> <input type="checkbox"/> <b>Email</b>	
Authorization/Revocation:	This authorization will terminate in one year unless otherwise specified: _____. I understand that I may stop this release at any time by writing to the Javery Pain Institute medical records department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Javery Pain Institute will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information.  X _____ X _____ <b>Signature</b> (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) <b>Date</b> _____ Relationship to patient (if not patient) <b>NOTE:</b> An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.  <p style="text-align: center;"><i>A photocopy of this authorization is as valid as the original.</i></p>	
Staff Use Only:	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____	