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Lenexa, Kansas 66215
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PINKERTON PAIN THERAPY

Medical Records
Release Authorization

Patient's Full Name		**Previous Name(s)**	
Social Security #		**Date of Birth**	
Address		**Phone #**	

A. **I hereby Authorize Records FROM:**	**Name:** **Address:** **City/State/Zip:**	**Phone #:**	**Fax #:**
B. To be Released TO:	**Name:** **Address:** **City/State/Zip:**	**Phone #:**	**Fax #:**

The request and authorization applies to:	**For the purpose of:**
Date Range: _____ to _____ ❑ Testing ❑ Physician Office Notes ❑ Operative/Procedure Reports ❑ Other _____	❑ Litigation ❑ Insurance ❑ Self/Personal Copy ❑ Transfer or Continuity of Care ❑ Disability ❑ Workers Comp ❑ Other

____ Initials required, 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 any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual organization or make disclosures.

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

____Intials required. 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 Medical REcords Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the rights to contest a claim under my policy.

____Initials required. I agree to pay the medical record state fee structure as set forth in the state statue. Our records request begins at the fee of $_____

I HAVE READ THE INFORMATION PROVIDED ON THIS RELEASE FORM AND DO HEREBY ACKNOWLEDGE THAT I AM FAMILIAR WITH AND FULLY UNDERSTAND THE TERMS AND CONDITIONS OF THIS AUTHORIZATION.

Patient Signature	**Date Signed**
X:	X:
This authorization will expire one year from above date unless I specify an expiration date:	**Expiration date of authorization if less than a year*