



Advanced Pain Management
 325 Clyde Morris Blvd, Suite 400 Ormond Beach, FL 32174
 Ph: 386-671-0600

RESTRICTED PHI AUTHORIZATIONS

Release of PHI (Personal Health Information):

I authorize Advanced Pain Management to speak to the following people on my behalf if needed and at anytime regarding my health care conditions. I understand that this authorization **will expire 1 year** from date signed and I can revoke this authorization at anytime. Request to change must be in writing to the Compliance Officer for Advanced Pain Management.

PLEASE READ CAREFULLY: initial each box for your approval: If you do not initial a box, then this information will be considered Restricted and your information will not be disclosed. (only person(s) who will be able to receive such information has been disclosed to you in the HIPAA regulations, in which you have signed).

(please initial boxes to give approval)

- PHYSICAN NOTES
- LAB RESULTS
- DIAGNOSTIC TESTS
- MEDICATIONS
- PHYSIOLOGIC NOTES
- DRUG TESTING RESULTS
- I DO NOT AUTHORIZE ANYONE TO MY INFORMATION AT THIS TIME.**

(Messages)

I Authorize APM to leave a detailed message on my voicemail regarding necessary information. The number I Authorize for messages is the following: _____.

I release the above information, which I have initialed to the following people below on my behalf

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

 Patient Signature: _____ Date: _____ (Expires 1 year from date)

 APM Witness: _____ Date: _____