The International Research Foundation for RSD / CRPS
*www.rsdfoundation.org*
*www.rsdhealthcare.org*

# AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

**PT LAST NAME:** _____ **PT FIRST NAME:** _____ **PT DATE OF BIRTH:**_____

**EMAIL:** _____

**PATIENT ADDRESS:** **STREET:** _____ **APT. #:**_____

**CITY:** _____ **STATE:** _____ **ZIP CODE:**_____

**TELEPHONE CONTACT #:** **DAY: (  )** _____ **EVENING: (  )** _____

I, _____ do hereby authorize the International Research Foundation for RSD / CRPS
(Patient Name/Legal Representative)
to release my protected health information including copies of my medical record of care received at the International Research Foundation for RSD / CRPS to the following persons at the locations/facilities listed below, for the purposes described:

| | Person(s)/Facility/Address (include name and address) | Purpose *(check the appropriate box)* |
|---|---|---|
| 1. | 2. | ☐ Medical Care<br>☐ Insurance<br>☐ Legal Matter<br>☐ Personal<br>☐ School<br>☐ Other (please specify)<br>_____<br>_____ |

***** There may be additional charges for copies of photographs and videos.***

## INFORMATION TO BE RELEASED *(Please check all that apply and specify dates):*

☐ Clinic visit notes _____
☐ Discharge Summary_____
☐ Lab Reports _____
☐ Operative Reports _____
☐ Pathology Reports _____
☐ Photographs** _____
☐ Radiation reports _____
☐ X-rays/Scan reports _____
☐ Other *(please specify)* _____
☐ Medical Record Abstract *(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)*

**See Page 2 on Reverse**

# AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

- ◯ Yes ◯ No **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.) **SPECIFY DATES** _____
- ◯ Yes ◯ No **Genetic Screening test results (SPECIFY TYPE OF TEST)** _____
- ◯ Yes ◯ No **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.
- ◯ Yes ◯ No **Other(s):** Please List _____
- ◯ Yes ◯ No Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) *(I understand that my permission may not be required to release my mental health records for payment purposes)*
- ◯ Yes ◯ No Confidential Communications with a Licensed Social Worker
- ◯ Yes ◯ No Details of Domestic Violence Victims' Counseling
- ◯ Yes ◯ No Details of Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

**Patient's Signature:** _____ **Date:** _____

**Print Name:** _____

Please print, sign, and fax to: 813-902-7911

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

**Signature of Legal Representative:**_____ **Date:** _____

**Print Name:** _____ **Relationship of representative to patient:** _____