

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION
(PLEASE PRINT CLEARLY)

PATIENT/AUTHORIZER INFORMATION: (Print, complete and sign this form, include **each and every provider** even if **YOU** provide the records)

Last Name: _____ First Name: _____ MI: _____
Current address: _____ City: _____
State: _____ Zip code: _____ Date of birth: _____ mm/dd/yyyy

REQUEST FOR RELEASE (Patient signature required)

By evidence of **signature** below, the above named **patient** requests medical records as specified below be released to **National Network for Chronic Intractable Pain, ("NNCIP")** for the purpose of continuity of care and to facilitate research into the long-term effectiveness of current protocols as well as the efficacy of alternative therapies for patients with chronic medical complaints. Patient expressly releases this information pertaining to ALL CURRENT AND RECENT TREATMENT INVOLVING PAIN to NNCIP. (Check all that apply)

- All general medical records, radiological reports, and lab reports dating back at least (3), three months up to two years. (if available)
- Pharmacy records dating back at least (3), three months up to two years. (if available)
- Limited records: (specify & explain the reason why only limited records are being released to NNCIP)

- Including psychiatric/psychological records. (if applicable)
- Including HIV/AIDS records, (if applicable) Patient signature: _____
- Other pertinent records: _____

This authorization is valid from: (today's date) _____ and expires on: _____ mm/dd/yyyy (typically one year)

PATIENT SIGNATURE (**Required**): _____ DATE: _____ mm/dd/yyyy

CURRENT & PREVIOUS PROVIDER INFORMATION - IDENTIFY **EVERY PROVIDER INCLUDING ALL PAIN RELATED TREATMENT** YOU HAVE RECEIVED DURING AT LEAST THE LAST THREE CONSECUTIVE MONTHS AND INCLUDING THE LAST TWO YEARS (**DISCLOSURE OF ALL PROVIDERS REQUIRED**)

IDENTIFICATION OF PRIMARY CARE PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED
(All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: _____ Phone: _____ Fax: _____
Organization, Facility, or affiliation: (if different than provider) _____
Provider address: _____ City: _____
State: _____ Zip code: _____ Date of last visit/consult: _____ mm/dd/yyyy

IDENTIFICATION OF OTHER PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED
(All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: _____ Phone: _____ Fax: _____
Organization, Facility, or affiliation: (if different than provider) _____
Provider address: _____ City: _____
State: _____ Zip code: _____ Date of last visit/consult: _____ mm/dd/yyyy

IDENTIFICATION OF OTHER PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED
(All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: _____ Phone: _____ Fax: _____
Organization, Facility, or affiliation: (if different than provider) _____
Provider address: _____ City: _____
State: _____ Zip code: _____ Date of last visit/consult: _____ mm/dd/yyyy

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CURRENT & PREVIOUS PROVIDER INFORMATION – CONTINUED - (DISCLOSURE OF ALL PROVIDERS REQUIRED)

IDENTIFICATION OF OTHER PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED
(All contact information is REQUIRED for each provider even if YOU are providing the records)

Name of Provider: _____ Phone: _____ Fax: _____
Organization, Facility, or affiliation: (if different than provider) _____
Provider address: _____ City: _____
State: _____ Zip code: _____ Date of last visit/consult: _____ mm/dd/yyyy

IDENTIFICATION OF OTHER PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED
(All contact information is REQUIRED for each provider even if YOU are providing the records)

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State: _____ Zip code: _____ Date of last visit/consult: _____ mm/dd/yyyy

ACKNOWLEDGEMENT OF PROHIBITION ON REDISCLOSURE

NNCIP acknowledges that this information is being disclosed from records whose confidentiality is protected by law. State and federal laws prohibit us from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by such laws. With regard to HIV/AIDS and psychiatric/psychological records (if applicable), a specific, written consent or a court order is required. A general authorization for the re-release of medical or other information is NOT sufficient for this purpose.

ADMINISTRATIVE INSTRUCTIONS

NNCIP requests the authorized records above including a copy of this document be faxed to: 1 (866) 424-5159
NNCIP, L.L.C. 7075 W. Bell Rd. Suite 7, Glendale, Arizona 85308
Phone: 1 (800) 846-6560 Fax: 1 (866) 424-5159