



RICHARD SIEGFRIED M.D.
COMPREHENSIVE PAIN MANAGEMENT

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The undersigned hereby authorizes _____ to use or disclose copies of certain medical record information as specified below:

PATIENT NAME _____ MEDICAL RECORD NUMBER _____
BIRTHDATE _____ SOCIAL SECURITY NUMBER _____
ADDRESS: _____ PHONE# _____

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE: _____ ENTIRE MEDICAL RECORD
_____ HISTORY AND PHYSICAL _____ DISCHARGE SUMMARY _____ OPERATIVE REPORTS
_____ LABORATORY REPORTS _____ X-RAY REPORTS _____ X-RAY FILMS
_____ PATHOLOGY REPORTS _____ PROGRESS NOTES _____ ORDERS

INFORMATION IS TO BE RELEASED TO:

(NAME) (ADDRESS) (CITY) (STATE) (ZIP CODE)

PATIENT TYPE: _____ EMERGENCY _____ INPATIENT _____ OUTPATIENT _____ OUTPATIENT SURGERY
DATES OF TREATMENT: _____
PURPOSE OR NEED FOR THIS DISCLOSURE OF INFORMATION: _____

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used, or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked, the automatic expiration date will be six (6) months from the date of signature or upon occurrence of the following event: _____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.
- THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). (SEE 63 O.S. § 1-502.2).

NOTICE TO RECIPIENT OF COPIES OF ALCOHOL AND DRUG ABUSE MEDICAL RECORDS:

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Chap. 1, Part 2, Subpart C § 2.32). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Chap. 1, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500 for the first offense and \$5,000 in the case of a subsequent offense.

THIS DOCUMENT SPECIFICALLY AUTHORIZES THE RELEASE OF PSYCHIATRIC INFORMATION. IF PSYCHIATRIC INFORMATION IS INCLUDED IN THE INFORMATION TO BE RELEASED TO THE PATIENT, PHYSICIAN CONSENT FOR SUCH RELEASE MUST BE OBTAINED

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release Richard N. Siegfried, M.D., L.L.C., its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

DATE / PATIENT SIGNATURE or LEGAL REPRESENTATIVE

COMPLETE THE FOLLOWING IF PATIENT IS DECEASED, A MINOR, OR MENTALLY INCAPACITATED.

AUTHORIZATION MAY BE GIVEN BY A LEGALLY AUTHORIZED REPRESENTATIVE, IDENTIFIED BELOW:

REASON PATIENT UNABLE TO SIGN / SIGNATURE

DATE RELATIONSHIP