Kikkeri International, Inc.
dba Advanced Pain Solutions

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ Date(s) of Service: _____*ALL*_____

Patient Date of Birth: _____ Social Security Number: _____

I, the undersigned, authorize the release of/or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

(✓) Continuing Medical Care ( ) Social Security/Disability ( ) Personal Use

( ) Legal Purposes ( ) Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

(✓) History & Physical (✓) Consultation Report (✓) Emergency Room Record

(✓) Operative Reports (✓) Discharge/Death Summary (✓) Face Sheet

(✓) Lab/Pathology Reports (✓) X-Ray Reports/Images (✓) External Prescription History

The above information may be released to:

_____

(Doctor, Hospital, Attorney, Insurance, Self, etc.) Phone Fax

_____

Street Address City State Zip Code

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used to disclose pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodefiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand that I may be charged a retrieval or processing fee for copies of my medical records according to Texas Hospital Licensing Law.

This authorization will expire upon discharge unless I revoke the authorization prior to that time or unless otherwise specified.

Patient/Guardian Signature: _____ Date: _____

If guardian, relationship to patient: _____ Printed Name: _____