

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Provider: PAIN MED PC
Michael Toshok DO
115 Center Avenue
Pittsburgh, PA 15215
(412)782-1500 fax (412)782-1505

Patient: _____

DOB: _____

Address: _____

I have been a patient of the foregoing medical provider, or I am the patient's authorized representative of guardian. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect my health care treatment, payment, enrollment or eligibility for benefits on the execution of the authorization in any way.

I, _____, hereby authorize the aforementioned medical provider to release and or disclose my protected health information, as hereinafter described to the following: (provider name, address, phone # and fax # or write self)

The aforementioned medical provider may release any and all medical information contained within my file, including but not limited to my treatment records and notes, consultation, lab/test results, diagnostic studies, hospital records, discharge summaries, progress notes, operative reports, outpatient records, and/or billing and itemized statements for services rendered. These records shall encompass the period of:

(Date) _____ to (Date) _____

Patient Signature

Witness if Representative and Not
Patient Signing Authorization

Date: _____

Date: _____