AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Provider: PAINMED PC
Michael Toshok, DO
434 Allegheny River Blvd
Suite 203
Oakmont, PA 15139
Ph (412)782-1500
Fax (412)828-3429

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 (if to self there is a a fee))

_____
_____
_____
_____
_____

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

Date: _____

_____
Witness if Representative and Not Patient Signing Authorization

Date: _____