**The Pain Treatment Center d/b/a Stone Road Surgery Center**
**280 Pasadena Drive**
**Lexington, KY 40503**
**Phone (859) 278-1316** **Fax (859) 260-2470**

## Authorization For Use and Disclosure of Protected Health Information

(Form must be filled out in its entirety or it will be returned.)

Patient Name:____________________________________SS#:______________________DOB: ____________

Address:____________________________________________________________Phone #:_________________

The undersigned hereby authorizes The Pain Treatment Center d/b/a Stone Road Surgery Center, to disclose medical information to ______________________________________________________ at
(Requestor)
_____________________________________________________________________________________________.
(Address) Must have City/State

**Information requested:** **Time Period:** From ____________________ to ____________________

[ ] Complete Medical Record
[ ] History and Physical Reports
[ ] Operative Reports
[ ] Other __________________
________________________

**How Disclosed:** [ ] On-site review [ ] Paper Copies - [ ] Patient will pick up [ ] Mail to above address
[ ] Fax to _______________ (healthcare providers only)

**Purpose of this disclosure:**
[ ] Request of Individual [ ] Other ____________________________________________________________

**I understand that this authorization expires:**
[ ] In six (6) months from the date on this form. [ ] Upon the happening of the following event:
(i.e. upon settlement of workers' comp case, etc.)
______________________________________________

By signing this form, I understand that my records will be provided to me within thirty (30) days of the receipt of this request. I also understand that I have the authority to revoke this form at any time by written request to be given to/mailed to Stephanie Lewis, Director of Medical Records for The Pain Treatment Center at the address listed above. I understand, however, that the revocation of this authorization will not have any effect on actions taken by The Pain Treatment Center prior to the revocation of this authorization and in reliance of this authorization. I also understand that the information disclosed may be subject to disclosure by the person(s) I have authorized to receive it and that the information no longer is protected by federal privacy regulations. Lastly, I understand that The Pain Treatment Center may not condition my treatment on whether or not I sign this authorization.

___________________________________ _____________ ________________________________________
Signature of Patient/Guardian Date Guardian's Name & Relationship (if applicable)

___________________________________ _____________
Witness' Signature Date

**REVERSE SIDE MUST BE COMPLETED IF REQUESTING OFFICE VISITS, DIAGNOSTIC STUDIES, LABS, OR ANY OTHER SERVICE PROVIDED IN THE PHYSICIAN SETTING.**