ACCELERATED RECOVERY SPECIALISTS
Musculoskeletal & Electrodiagnostic Medicine

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

TO ACCELERATED RECOVERY SPECIALISTS, P.C.

Patient Name _____ Birthdate_____/_____/_____

Address_____City_____State_____Zip_____

I hereby authorize the disclosure of my protected health information to Accelerated Recovery Specialists, P.C. as described below:

Information to be released:

❍ Medical History, Examination Reports
❍ Treatment or Tests
❍ X-ray Reports/Films
❍ Laboratory Reports
❍ HIV Test Results*
❍ Mental Health
❍ Sexually Transmitted Disease
❍ Alcoholism
❍ Surgical Reports
❍ Hospital Records including reports
❍ Developmental Disabilities
❍ Prescriptions
❍ Consultations
❍ Allergy Records
❍ Drug Abuse
❍ Other (Please Specify)_____

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure

❍ At the request of the individual
❍ Other (Please Specify)_____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

❍ Receive a copy of this authorization.
❍ Revoke this authorization, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s):_____

Patient Signature_____ Date_____