PAIN MANAGEMENT OF WILLIAMSPORT, LLC
AYAZ M. KHAN, M.D.
(570) 323-3106

"Helping you manage your pain"

* PAIN MANAGEMENT SERVICE:

* DATE:

* PATIENT NAME:

* ADDRESS:

* PHONE NUMBER:

* DATE OF BIRTH:

* SOCIAL SECURITY NUMBER:

* INSURANCE:

PRE-CERTIFICATION:

* INSURANCE NUMBER:

NAME:

REFERRED BY:

PHONE NUMBER:

REFERRAL LETTER REQUESTED: ☐

RECEIVED: ☐

MAJOR COMPLAINT:

COMMENTS:

PAIN MANAGEMENT OF WILLIAMSPORT, LLC

Medical Information (HIPAA) Release Form: Patient

Name: _____

Date of Birth: _____/_____/_____

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

_____

☐ Other _____

☐ INFORMATION MAY NOT BE RELEASED TO ANYONE

This release of information will remain in effect until **terminated by me in writing**.

To leave messages, please call:
☐ home phone number (_____) _____ - _____
☐ work phone number (_____) _____ - _____
☐ cell phone number (_____) _____ - _____

The best time to reach me is _____ between _____ to _____ (☐ am/☐ pm).

Signature (patient): _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

CONSENT FOR RELEASE OF INFORMATION

I, _____, born on _____
(patient name) (patient birth date)

SSN _____, authorize _____ to
(patient social security #) (clinic or doctor's name)

disclose to PAIN MANAGEMENT OF WILLIAMSPORT, LLC
(name and location of person/ organization to receive information)

the following information: _____.

The purpose of this disclosure is: _____.

This authorization expires on: _____, or

whenever _____ is no longer providing me with services.

I understand that my records are protected under the Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of patient _____ Dated _____

Signature of witness _____ Dated _____

ATTENTION RECIPIENT:
Notice Prohibiting Redisclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.