Authorization for Disclosure of Protected Health Information

nura
Precision Pain Management

Date Information Desired by:	Patient Name: _____ Date of Birth: _____
	Address (including City/State/Zip): _____
	Phone Number: _____
	Maiden/Previous Names/Nicknames:

Instructions: fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Release Information From:	**Release Information To:**
Provider/Facility Name: Nura P.A.	**Name/Facility:**
Address: 2104 Northdale Blvd. NW, Suite 220	**Address:**
City/State/Zip: Coon Rapids, MN 55433	**City/State/Zip:**
Phone: 763-537-6000 ext. 7150 for medical records	**Phone:**
Fax: 763-767-7149	**Fax:**

Purpose of Release:

☐ Continuing Care	☐ Personal	☐ Transfer of Care	☐ Disability Determination
☐ Legal	☐ Work Comp	☐ Insurance	☐ Other _____

Information to be Released:

Release Method: ☐ Mail ☐ Fax ☐ Secure Email ☐ Pick Up: Edina or Maple Grove on _____
(Circle One) (Please list date and time)

Service Dates: From: _____ To: _____

☐ Entire Medical Record	☐ Laboratory Reports	☐ Other (Please specify): _____
☐ Operative/Procedure Notes	☐ Radiology Reports	
☐ Office Visit Notes	☐ Billing Statements	

I do not want the following information disclosed (as defined by applicable state and federal laws):

☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AIDS ☐ Alcohol/Drug Abuse ☐ Genetic Information

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Refuse to Sign This Authorization. I understand that I have the right to refuse to sign this Authorization and NURA will not condition treatment or payment upon my signing of this Authorization.

Right to Revoke Authorization. I understand that I have the right to revoke this Authorization, except to the extent that NURA has already disclosed my medical information in reliance of Authorization. I understand that my revocation is effective only if it is in writing. To revoke my Authorization I understand that I must send a written request for revocation to NURA's corporate medical records staff, Attn: Medical Records Supervisor.

Re-disclosure of Information by Recipient. I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person(s)/organization(s) receiving my medical information and no longer protected by applicable privacy laws.

Right to Receive a Copy of This Authorization and My Medical Information. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I also have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization.

By signing this form I am authorizing Nura Precision Pain Management and its affiliates and subsidiaries ("NURA") to disclose my medical information as described in this Authorization

Signature (required):	**Date Signed** (required):
Printed Name of Person Signing:	
Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased	
Legal Authority: ☐ Parent of minor ☐ Legal Guardian ☐ Activated Power of Attorney ☐ Next of Kin	