

Authorization for Disclosure of Protected Health Information



Patient Name: _____	DOB: _____
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. ****

I hereby authorize Nura PA to (choose one):	<input type="checkbox"/> Disclose my protected health information as indicated below TO:
	<input type="checkbox"/> Obtain my protected health information FROM:

Facility/Provider Name: _____	
Street Address: _____	Phone: _____
City, State, Zip: _____	Fax: _____

Purpose of Release:

<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Personal	<input type="checkbox"/> Transfer of Care	<input type="checkbox"/> Disability Determination
<input type="checkbox"/> Legal	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other _____

Information to be Released:

Release Method:	<input type="checkbox"/> Mail	<input type="checkbox"/> Fax	<input type="checkbox"/> Secure Email	<input type="checkbox"/> Pick Up: Edina or Maple Grove on _____
				<small>Circle One Please list date and time</small>
Service Dates:	From: _____	To: _____		
<input type="checkbox"/> Office Visit Notes	<input type="checkbox"/> Behavioral Health Evaluations	<input type="checkbox"/> Radiology Reports		
<input type="checkbox"/> Operative/Procedure Notes	<small>(First visit, implant eval or updated eval)</small>	<input type="checkbox"/> Billing Statements		
<input type="checkbox"/> Physical Therapy Notes	<input type="checkbox"/> Behavioral Health Psychotherapy Notes	<input type="checkbox"/> Other (Please specify): _____		
<input type="checkbox"/> Laboratory Reports	<small>(Follow-up appointments)</small>	_____		

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

Behavioral Health/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: <input type="checkbox"/> Minor <input type="checkbox"/> Incompetent <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased	
Legal Authority: <input type="checkbox"/> Parent of minor <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Activated Power of Attorney <input type="checkbox"/> Next of Kin	