Authorization for Disclosure of Protected Health Information

Updated 5/10/23 V.1

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):	☐ Disclose my protected health information as indicated below **TO:**
	☐ Obtain my protected health information **FROM:**

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

Purpose of Release:

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

Information to be Released:

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

Area of Pain: _____

Start Date: _____ **End Date:** _____

☐ Last 3-5 visit notes	☐ Laboratory Reports	☐ Radiology Reports
☐ Office Visit Notes	☐ Behavioral Health Evaluations (First visit, implant eval or updated eval)	☐ Billing Statements
☐ Operative/Procedure Notes	☐ Behavioral Health Psychotherapy Notes (Follow-up appointments)	☐ Other (Please specify): _____
☐ Physical Therapy Notes		

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: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased	
Legal Authority: ☐ Parent of minor ☐ Legal Guardian ☐ Activated Power of Attorney ☐ Next of Kin	

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