Authorization Form to Use and Disclose Protected Health Information

Your name: ____________________ Your date of birth: ____________________

Your address: Your phone number: ____________________

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I understand that **Physician Pain Specialists, P.C. is closing on October 30, 2015** and will not see or treat patients after that date.

Please send all records relating to my care by Physician Pain Specialists, P.C. to the person and address provided below. I am requesting this transfer of my records as a result of the closure of Physician Pain Specialists, P.C.

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I understand that this authorization will expire one (1) year from the date of signature below.

Furthermore, by signing below, I understand that:

- my personal information will be released to the person listed above;
- this information may include information regarding mental health, drugs & alcohol, HIV/AIDS and other communicable diseases, and/or genetic testing if such information is in my records held by Physician Pain Specialists, P.C.;
- I may revoke this authorization by providing a written notification of my desire to revoke it to Physician Pain Specialists, P.C. at the address provided above prior to December 30, 2015. However, if Physician Pain Specialists, P.C. has already released my records in reliance on this authorization, that release cannot be reversed, and my revocation will not affect that release;
- Physician Pain Specialists, P.C. may not condition its treatment of me (through October 30, 2015) on whether or not I sign this authorization; and
- information released pursuant to this authorization may no longer be protected by federal privacy regulations.

____________________ ____________________

Signature of Individual or Personal Representative Date

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Description of Personal Representative's Authority (if applicable)

5671 Peachtree Dunwoody Road NE • Suite 660 • Atlanta, GA 30342 • Phone: 404-256-5405 • Fax: 404-303-1418 • Web: www.psa-online.net