## **Authorization to Release Information**

		and Accountability Act (HIPP	
, hearby authorize			, to disclose
th	ne following protected her	alth information:	
*	Progress Notes		
*	'- '- '-	otes	
<del>-</del>	Prescription Medications		
*			
*			
*	Radiology Imaging/Lal		
Release this information to:	Provider Name		
	Fax #		
	Phone #		
********	*******	**********	*****
I understand that a revocation	Applied Pain Ins 1015 S Mercer Bloomington, IL Attn: Office Ma n is not effective to the ex or disclosure of the prote	Ave 61701 nager xtent that Applied Pain Institu	ite has relied on
the use t	or disclosure of the protect	cted ficular finormation.	
I understand Applied Pain Inst	itute can charge me for co state law.		ance with Illinois
I understand I have the right to	ı <b>:</b>		
	Inspect or copy my protected health information to be used or disclosed as		
•	• • • •	state law to the extent the sta	
	access rights.)		
* Refuse t	sign this authorization.		
Print Name:			
Date:			

A copy of this signed authorization must be provided to the patient.