ADVANCED DIAGNOSTIC PAIN TREATMENT CENTERS

One Long Wharf Drive, Suite 212
New Haven, CT 06511

Dwight P. Ligham, M.D.

Phone (203) 624-4208
Fax (203) 624-4301

Authorization for Access/Release of Information

Patient Name: _____ DOB: _____ Phone: _____
Address: _____

I hereby authorize Advanced Diagnostic Pain Treatment Centers, PC

❑ **to obtain information from:** ❑ **to release information from my medical record to:**

Name: _____ Phone: _____
Address: _____ City/State: _____ Zip Code: _____
Fax: _____ Email: _____

Description of the Purposes of the Requested Disclosure:

❑ Personal ❑ Continuing Care ❑ Legal ❑ Disability ❑ Workers Comp ❑ Other: _____

Method of Disclosure:

❑ Mail ❑ Fax: _____ ❑ Secure Email: _____
❑ Pick-up please indicate how you would like to be contacted when ready for pickup: : _____
Dates of Service: _____

Medical Information Requested:

_____ Entire Medical Record _____Office Notes _____ Operative/Procedure Report _____ Itemized Bill
_____ Laboratory Test Results _____ Radiology Images _____ Other

*****HIV – BEHAVIORAL HEALTH – DRUG/ALCOHOL INFORMATION contained within the medical records indicated above will be released through this authorization. (Medical records containing any of the protected information below must also be signed by the parent if a minor age 13 or older, with the exception of Behavioral Health, which also requires authorization by the patient if minor age is 16 or older.)*****

Conditions of Authorization

I understand ADPTC will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the authorization.

I understand that I may revoke this Authorization at any time by providing written notice to ADPTC. Cancellation of the authorization will not apply to information that has already been released based on this authorization.

I understand the information disclosed in response to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Federal Privacy Regulations.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event, or condition, this Authorization will expire in one year.

_____ _____
Date Signature of patient or person granting authorization on behalf of patient

If signed by the Legal Representative, indicate your relationship to the patient below and attach a copy of documentation:

❑ Conservator ❑ Power of Attorney ❑ Executor of Estate ❑ Other: _____