Permission to Discuss

Patient Name (First, MI, Last)____

Mailing Address____Town/City/Zip______________________________

Phone Number (H)____ (C)________________________ (W)________________

I ____give Permission to Granite State Pain Associates/Granite State SurgiCenters., to discuss/release the following medical information about me.

(Check all that apply):

- [ ] Medical information, including but not limited to, my symptoms, diagnosis, medications and treatment plan.
- [ ] Behavioral health information, including but not limited to, my symptoms, diagnosis, medications and treatment plan
- [ ] Chemical Dependency information, including but not limited to, my symptoms, diagnosis, medications and treatment plan
- [ ] Lab, X-Ray/other test results
- [ ] Only medical information related to: ____
- [ ] Billing Questions (Balances , Insurance Issues & Copies of Bills)
- [ ] Appointments: Schedule, Verify and/or Cancel Appointments
- [ ] Other (be specific) ____

Granite State Pain Associates/Granite State SurgiCenters has my Permission to discuss/release the above information with:
(spouse, parent, probation officer, lawyer)

Name: ____
Address: ______________________________________
City, State, Zip: _______________________________
Phone: ____
Relationship: __________________________________

Name: ____
Address: ____
City, State, Zip: ____________________________________
Phone: ____
Relationship: _______________________________________

Medical records are defined as: *All health information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status an/or diagnosis of AIDS and /or other sexually transmitted diseases including hepatitis, unless restricted above.*

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer protected under federal law.

____ **Date**: ________________
Signature of Patient or Legal Representative