Comprehensive Rehabilitation & Pain Specialists, P. C.
135 E. Rich Blvd, Elizabeth City, NC 27909

Authorization

To be completed by the health care provider:

Patient Name: _____ **Patient ID #:** _____

Persons/organization providing the information:
Comprehensive Rehabilitation & Pain Specialists, P.C.
135 E. Rich Blvd
Elizabeth City, NC 27909
252-333-1277 Fax 252-333-1877

Persons/organization receiving the information:

Specific description of information including dates(s):
Please copy and transfer all of my medical records, for all dates of service, to myself at the above address..

The information described above will be used or disclosed for the following purpose(s):
Further medical treatment

Expiration date:
This authorization will expire: ☐ 60 days ☒ 90 days or ☐ Other _____ from date signed.

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above.

I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to: The Facility Privacy Officer at the above address. Any revocation will not affect disclosures made prior to CRPS's receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

I certify that I have received a copy of this authorization.

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Relationship to the patient: _____