

Association of Specialty Physicians, Inc.
Patient Authorization for the Disclosure of
Health Information To Employer

I hereby authorize employees, medical staff members or other agents of Association of Specialty Physicians, Inc to release my medical record related to my work injury that occurred on

(Date of Injury)

This authorization also releases information pertaining to any and all work related testing.

(Employer)

(WC Insurance)

(Any and All Treating Physicians)

This Authorization expires:

___ On the following date: ___/___/___ or One (1) year from date signed

___ When the following event occurs: _____

(This form does not authorize the use or disclosure of psychotherapy notes. This form may not be used to authorize the use or disclosure of any other Protected Health Information. A separate Authorization is needed for any other use or disclosure).

___ Health information is being released to allow the individuals listed above to more actively participate in the patient's care.

___ Other (describe): _____

Patient Name (Print)

Date of Birth

Patient Signature

Date

Witness

Date

You may revoke this consent in writing at anytime.