David L. Spivey, MD
Medical Director
Board Certified, Pain Medicine

Jeffery A. Adams, MD
Board Certified, Pain Medicine

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Preferred
Pain Management & Spine Care

Relieve Pain. Restore Function...Resume Life.

2912 Maplewood Avenue
Winston-Salem, NC 27103
336.760.0706 ph
336.760.1927 fx

1511 Westover Terrace, Suite 107
Greensboro, NC 27408
336.398.5155 ph
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Authorization to Use or Disclose Health Information

Patient Name (print): _____ Date of birth: _____

1. I authorize _____ ("Record Holder") to release my individual health information or medical record as described below.
2. The type of information to be released or disclosed is as follows (check the appropriate boxes and include other information where needed)

   □ Office Note □ Prescription History □ Consultation Note
   □ Laboratory Result □ Radiology Report □ Operative/Procedure Report
   □ Other: _____
3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, ADHD, behavioral or mental health services or alcohol and drug abuse.
4. The information identified above may be used or disclosed to the following individual(s) or organization(s):

   Name of Organization or Individual: **Preferred Pain Management and Spine Care**

   Address: **1511 Westover Terrace Suite 107, Greensboro, NC 27408**

   Phone Number: **336-398-5155** Fax Number: **336-398-5156**
5. This information for which I am authorizing disclosure will be used for the following purpose:
   □ sharing with other health care providers
   □ Other: _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. This authorization will expire on _____. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations.
9. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment from the Record Holder.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date