726 East Side Blvd
Hastings, NE 68901
Phone : (402) 834-3368
Fax : (402) 834-3364
Email :hapainrelief@haprc.org
Web : www.haprc.org

HASTINGS
PAIN RELIEF CENTER
'Our Belief, Your Pain Relief'

Authorization to release healthcare information

Patient's Name:_____ Date of Birth: _____

Previous Name:_____ Social Security #: _____

Patient's Home Phone:_____ Patient's Work/Cell Phone: _____

Patient's Address: _____

I request and authorize Dr._____ Phone number: _____

Address:_____ Fax number: _____

To release healthcare information of the patient named above to:

Hastings Pain Relief Center, PC

726 East Side Blvd

Hastings, NE – 68901

PLEASE FAX RECORDS TO (402) 834 – 3364

This request and authorization applies to:

- ☐ All healthcare information
- ☐ Healthcare information relating to the following treatment, condition or dates:

  _____

  _____
- ☐ Other: _____

_____Yes_____No I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

X_____ _____

Signature of Patient / Parent or Authorized Representative Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.