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**CONSENT TO DISCLOSE OR OBTAIN**

**PRIVATE HEALTHCARE INFORMATION**

**FOR TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby authorize and Consent for the Migraine Relief Center to:

**( ) RELEASE or ( ) OBTAIN**

Any medical, dental, psychological reports, operative notes, discharge summaries, Doctor’s/Dentist orders, Nurse’s notes, lab reports, tests results, physical therapy progress notes, patients progress reports, diagnosis, pathology reports, x-rays, MRI’s, any records reflecting treatment for studies, laboratory slides, clinical abstracts, histories, charts, and other information contained therein, any documents and opinions relevant to past, present or future physical and mental condition, treatment, care or hospitalization, and any other personal information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and /or conduct other healthcare operations.

The release or to obtain the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

This Consent to Disclose or Obtain Private Healthcare information may be revoked in writing, However, such revocation shall not be effective on an entity that has taken action in reliance upon this Consent Prior to its revocation and/or if this Consent was obtained as a condition of obtaining insurance and a law provides the insurer the right to contest a claim under the policy.

Any person, firm or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further acknowledge that the information used or discloses pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

I further understand that I have the right to review Migraine Relief Center privacy notice and to request restrictions.

Signed this \_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Printed Name of Patient*** ***Signature of Patient***

**Special Restrictions to withhold Medical Records:** **Send Medical Records To:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Person or Clinic Name*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Address*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*City/State/Zip*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Telephone No.*