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.