



7306 Highway 11
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Physician services provided by Physician Practice Operations Group, PLLC "PPOG" for Restore Pain Center, LLC

COMBINED HIPAA AUTHORIZATION

Release of Medical Records & Disclosure of Protected Health Information

Patient Full Name: _____ **Date of Birth:** _____

SECTION A: Authorization for Release of Medical Records TO Restore Pain Center

This section allows Physician Practice Operations Group, PLLC (PPOG) to obtain your protected health information from outside providers for purposes of evaluation, diagnosis, treatment, and compliance with Mississippi prescribing and monitoring requirements.

Records to Be Released From (Provider/Facility Name): _____

Address: _____

Phone: _____ **Fax:** _____

Information to Be Released:

☐ Office visit notes ☐ Hospital / ER records ☐ Imaging reports (MRI, CT, X-ray)
☐ Operative reports ☐ Medication history ☐ Laboratory results ☐ Other: _____

SECTION B: Authorization for Use and Disclosure of Protected Health Information BY Restore Pain Center

This section allows PPOG and Restore Pain Center, LLC to use and disclose your PHI (including all medical records, clinical notes, diagnostic tests, lab results, UDS results, and prescription records) for purposes of treatment, payment, healthcare operations, care coordination, and compliance.

Persons Authorized to Disclose and Receive Information: PPOG, Restore, affiliated providers, pharmacies, laboratories, consultants, auditors, and regulatory authorities as permitted by law.

SECTION C: Expiration, Revocation, and Acknowledgment

Expiration: This combined authorization shall remain in effect until revoked in writing or until the termination of the patient-provider relationship.

Revocation: I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.

Acknowledgment: I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA.

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____

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Hours
By Appointment Only