Southern Pain and Rehab, LLC **Michael J. Kohrman MD** www.southernpainandrehab.com

Board Certified Physical Medicine & Rehabilitation
EMG/NCV's, IME's, Interventional Pain, Non-Surgical Spine, Sport, Shoulders, Hips, Knees & more
Hours by Appointment

26211 Equity Drive Suite A Daphne, Alabama 36526-6189 Phone: 251-626-0901 Fax: 251-626-0902

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____, DOB: ________ / ________ / ________
hereby authorize **Southern Pain and Rehab, LLC / Michael J. Kohrman, MD** (check the following that apply):

To use the following protected health information from:

_____________________________________ _____________________________________

_____________________________________ Tel: _________________________________

_____________________________________ Fax: _________________________________

To disclose the following health information to:

_____________________________________ Relationship to Patient: _______________________

_____________________________________ Tel: _________________________________

_____________________________________ Fax: _________________________________

(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors, such as date of service, type of service provided, level of detail to be released, origin of information, etc.)
This protected health information is being used or disclosed for the following purposes: Continuation of Care.

All Office Notes	EMG / NCV Test Results		Physical Therapy Notes	
Procedure Reports:	Interventional Procedures		Surgery Report	
Radiology Test Results:	X-rays	MRIs	Bone Scan	CT Scans
Diagnostic Test Results:	Dopplers	Ultrasounds	Sleep Study	Blood work
Prescription Print Out for the last year		Other: ______________________________		

PLEASE FAX RECORDS TO DR. KOHRMAN AT: (251) 626-0902 OR MAIL TO THE ADDRESS ABOVE.

This authorization shall be in force and effect until ______________________________________
(SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE)
or **one year from the date of this authorization**, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Ms. Susan Kohrman at Southern Pain and Rehab, LLC. I understand that a revocation is not effective to the extent that Michael J. Kohrman, MD has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Southern Pain and Rehab, LLC / Michael J. Kohrman, MD will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

____ ____________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority