PAIN CONSULTANTS of ARIZONA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: ______________________________________ DATE OF BIRTH: ________________

I authorize the use or disclosure of the above named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

Name:____

Address: ____

Phone:_____________________________________Fax:____

The type and amount of information to be used or disclosed is the entire medical chart, including medical records, Office notes, hospital records, pharmaceutical records, laboratory records, X-ray and MRI films, CAT scans, any other radiological films, and medical bills.

I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, pregnancy and/or family planning.

This information may be disclosed to and used by the following individual or organization:

Pain Consultants of Arizona
20950 N Tatum Blvd, Ste 300 * Phoenix, AZ 85050
Ph: 480-222-PAIN * Fx: 480-222-7271

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains the health insurance.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: ____ Date: _________________________

Witness Signature: ____ Date:_________________________