PACIFIC PAIN MEDICINE CONSULTANTS

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you.

Name of patient:_____Date of birth: _____

I hereby authorize: _____ to release to:

_____

(Persons/Organizations authorized to receive the information) Address/fax Number

The following information:

a. □ All health information pertaining to my medical history, mental or physical condition and treatment received; or
   □ Only the following records or types of health information:

_____

b. I specifically authorize release of the following information (check as appropriate):

   □ Mental health treatment information _____ (initial)
   □ HIV test results _____ (initial)
   □ Alcohol/drug treatment information _____ (initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

PURPOSE of requested use or disclosure: □ Patient request; or □ Other: _____

Limitations, if any: _____

EXPIRATION. This authorization expires on (date): _____

Name of patient: _____ Date of Birth: _____

MY RIGHTS. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **PACIFIC PAIN MEDICINE CONSULTANTS 477 N El Camino Real, Suite B301, Encinitas, CA 92024.** I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of the authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE: _____ Date: _____
Patient/legal representative

If signed by a person other than the patient, indicate relationship: _____

Print name: _____
(Of legal representative)

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