AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Southwest Pain Group
Put your Pain in the Past.

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NAME OF PATIENT

_____

Last First Middle

OTHER NAMES USED_____

DATE OF BIRTH Month_____ Day_____ Year_____

ADDRESS _____

CITY_____**STATE**_____**ZIP**_____

EMAIL ADDRESS (Optional)_____

PHONE (_____)_____ **ALTERNATEPHONE** (___)_____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name_____

Address _____

City_____State_____Zip Code_____

Phone (____)_____Fax (____)_____

WHO IS TO RECEIVE AND USE THE HEALTH INFORMATION AND HOW?

Person/Organization Name_____

Address _____

City_____State_____Zip Code_____

Phone (____) _____Fax (____) _____

REASON FOR DISCLOSURE

(Choose only one below)

Treatment/Continuing Care ____

Personal Use ____

Legal Purposes ____

Insurance, Billing or Claims ____

Disability Determination ____

Other _____

Hold for Pick up____ Mail____ Email ___ Fax____

WHAT INFORMATION CAN BE DISCLOSED? If all health information is to be released, then check only the first space.

____ **ALL HEALTH INFORMATION** ____ History/Physical Exam ____ Progress Notes ____ Procedure Notes

____ Lab Results ____ Medication Records ____ Imaging Reports Other _____

Your initials are required to release the following information: ____ Mental Health Record ____ Drug, Alcohol or Substance Abuse Records

____ Genetic Information (Including Genetic Test Results) ____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD: This authorization is valid for one year from the undersigned date. I understand my request will be acted upon within 30 days. A photocopy of this authorization is as valid as the original.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving notice stating my intent in writing.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ DATE _____

REPRESENTATIVE SIGNATURE (with power of attorney attached)_____ DATE _____

_____ I UNDERSTAND THAT I WILL BE REQUIRED TO PAY THE COST OF PREPARING AND MAILING THESE RECORDS.

FOR OFFICE USE ONLY: DATE RECEIVED: _____ FEE COLLECTED: $_____ DATE FILLED_____