



AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of health information as follows:

Patient Name: _____ MR# _____

Date of Birth _____ Date of Discharge (if applicable) _____

The following individual or organization is **authorized to make the disclosure**:

Name of Provider: _____

Address of Provider: _____

Fax Number: _____

Persons/Organizations **authorized to receive this information**:

Name of Provider: _____

Address of Provider: _____

Fax Number: _____

My health information will be used for the following purpose(s) – to be completed by the person/organization requesting your information:

This Authorization applies to the following information (please select only **one** of the following):

[] All of my health information that the provider has in his or her possession, including health relating to any medical history, mental or physical condition and any treatment received by me, including without limitation: x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold.

[] All of my health information described above except for the following:

[] Only the following records or types of health information (types of treatment or other designation):

_____ Dates: _____

EXPIRATION

This Authorization expires one year from the date this authorization is signed.

SIGNATURES

Signature _____ Date ___/___/___ Time _____AM/PM
[patient/representative/spouse/financially responsible party]

If signed by someone other than the patient, state your legal relationship to the patient:

[A spouse or financially responsible party may only authorize the release of the medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service plan or employee benefit plan.]

Witness _____ Date ___/___/___ Time _____AM/PM

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the following address: Premier Pain Consultants, 270 Laguna Rd Suite 220, Fullerton, CA 92835.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have the right to receive a copy of this Authorization.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. This does not apply if the Requestor is seeking to use this information as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member, (iii) to enable the Requestor to determine its obligation to pay a claim, or (iv) to create health information to provide to a third party. Under no circumstances, however, am I required to authorize the disclosure of psychotherapy notes.

