COMPREHENSIVE PAIN SPECIALISTS

Authorization for Center for Physical Medicine and Rehabilitation to Use or Disclose My Health Information

Patient name: _____ Date of Birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted: _____

_____

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ All Psychotherapy notes unless specifically excepted: _____

☐ Other: _____

You may disclose this health information to:

Name (or title) and organization _____

Address: _____

City _____ State _____ Zip_____

Reason(s) for this authorization (check all that apply):

☐ at my request _____

☐ other (specify) _____

_____

_____

☐ check here only when (physician or clinic) requests the authorization for marketing purposes

☐ check here only when (physician or clinic) will get something of value for providing health information for marketing purposes

This authorization ends: ☐ on (date) _____

☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

Patient or legally authorized individual signature	Date
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)