THE PAIN CENTER SAN DIEGO

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name (with maiden name):	DOB:
Other name used here:	Phone Number: (provide at least one phone number in case we have any questions regarding your authorization) (Home) (Cell)

ONLY ONE *PERSONAL* COPY OF YOUR MEDICAL RECORD IS FREE OF CHARGE

Information to be DISCLOSED by:
Name: Pain Center – San Diego PC
Phone: 619-578-3740 Fax: 208-342-4223
MAILING Address: 633 N 4th Street, Boise, ID 83702
(formerly 4033 3rd Ave, Suite 200, San Diego, CA 92103)
E-Mail: admin@thepaincentersandiego.com

Information to be RECEIVED by: (fax/email required if that is requested method of transmission)
*Name: ______________________ Fax: ____________
*Address: ______________________
*City, State, Zip: ______________________
Email: ______________________

SEND MY RECORDS TO THE ABOVE VIA (CHOOSE ONE):
❑ USPS MAIL ❑EMAIL* ❑FAX*

*The information is to be used exclusively for: ______________________

*The information to be disclosed is specified as follows: ❑ Complete medical record ❑Date Range: ____________

OR SELECT WHAT RECORDS FROM THE FOLLOWING:

❑**Inpatient/Outpatient Surgery**	❑ **Emergency Department** Records	❑ **Outpatient Diagnostic Tests**	❑ **Medical Record from The Pain Center – San Diego PC**
Date(s) ____________	Date(s) ____________	Date(s) ____________	Date(s) ____________
❑Discharge summary	❑ ER Report	❑ Laboratory	❑ Discharge Summary
❑History and physical	❑ Complete record	❑ X-rays/MRI/CT reports	❑ History and physical
❑Operative Report	❑ ____________	❑ Nuclear Med Reports	❑ Treatment summary
❑Pathology Report	❑ **Pain Center – San Diego PC Billing Records**	❑ EEG report	❑ Laboratory reports
❑Orders	Date(s) ____________	❑ EKG report	❑ Follow-up Reports
❑Laboratory	❑ Claim Form	❑ Vascular Study	❑ Consultations
❑X-Rays	❑ Detailed bill	❑ Sleep Study	❑ Progress Notes
❑Pertinent Record Set		❑ Echocardiogram	❑ X-Rays/MRI/CT/Nuclear
❑ ____________	❑ **Other Outpatient Dept**	❑ Pulmonary Test	❑ EKG
❑ ____________	❑ ____________	❑ ____________	❑ ____________
	❑ ____________	❑ ____________	❑ ____________
	❑ ____________	❑ ____________	❑ ____________
		❑ ____________	

I understand that the information described above may be re-disclosed in which case it is no longer protected by patient privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment, or health care operation's, not is my treatment or payment for treatment conditional on my signing this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that information has already been released and/or used in response to this authorization, or an authorization, otherwise received by The Pain Center – San Diego. Unless otherwise revoked, this authorization will expire on the following date or event: ________________. If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

SPECIFIC AUTHORIZATION

*I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, except as crossed out, and initialed here: _______ initials

***SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE** ***DATE**

______________________________ ____________________

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

______________________________ ____________________

INTERNAL USE ONLY:

DATE COMPLETED FORM RECEIVED: ____/_____/_____ RECORDS TO BE SENT TO: ❑ PATIENT ❑ OTHER: ________________
TRANSMISSION METHOD IS: ❑ USPS ❑ EMAIL ❑ FAX TO: ______________________
RECORDS SENT VIA: ❑ USPS ❑ EMAIL ❑ FAX DATE RECORDS SENT: ____________________