AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Dr. / Facility Name: _____

_____

_____

Phone: _____ Fax: _____

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes, chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

_____

Print Patient Name Date of Birth

Date(s) of Service (if known): _____

Description of information to be released: ***ALL MY HEALTH INFORMATION DESCRIBED ABOVE UNLESS SPECIFICALLY EXCEPTED***: _____

_____

The reason or purpose of the use and/or disclosure: _____

_____

The health information described herein shall be released to: ____ Hospital ____ Physician ____ Patient ____ Attorney ____Insurance Company ____ Other (Check appropriate category and list information below.)

DESERT PAIN AND REHAB SPECIALISTS **11047 N. 19TH AVE.** **PHOENIX, AZ 85029**

Name Address City, State, Zip Code

**** * * RECORDS MAY ALSO BE FAXED TO: 602-331-2499 * * ****

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify by date or event. I desire this authorization to be in effect until _____(expiration date/event.)

I further understand that I may revoke this authorization at any time by notifying the HIPPA compliance officer at the facility where the records are being requested from. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative

_____ or _____

Relationship to Patient Legal Authority (Attach supporting documents)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize **DESERT PAIN AND REHAB SPECIALISTS, 11047 N. 19TH AVE., PHOENIX, AZ 85029** to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes, chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Print Patient Name _____ Date of Birth _____

Date(s) of Service (if known): _____

All my health information as described above, unless specifically excepted: _____

_____

The reason or purpose of the use and/or disclosure: _____

_____

The health information described herein shall be release to: ____Hospital ____ Physician ____ Patient

____Attorney ____ Insurance Company ____ Other (Please check the appropriate category and list information below)

_____

Name Address City State Zip Code

I understand that this authorization will expire, by law, 180 days from the date of this authorization unless I otherwise specify by date or by an event. I desire this authorization to be in effect until _____ (expiration date/event).

I further understand that I may revoke this authorization at any time by notifying **DESERT PAIN AND REHAB SPECIALISTS** in writing at **11047 N. 19TH AVE., PHOENIX, AZ 85029**. I also understand that the written revocation must be signed and dated with a date that is later than the authorization. The revocation will not affect any actions taken before the receipt of this written revocation.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative

_____ or _____

Relationship to Patient Legal Authority (attach supporting documents)