
Patient Name

Date of Birth

PATIENT'S REPRESENTATIVE AUTHORIZATION

In accordance with new federal regulations we are not allowed to discuss or even acknowledge that you are a patient of Desert Pain Institute without your expressed written consent. If there is anyone (i.e.: spouse, parent, child, neighbor, etc.) you think might ever have a need to discuss your medical condition, your treatments, your appointments, or your financial account please list them below. This will prevent us from having to get your written consent each time they call to handle matters on your behalf.

Mark each purpose for which you are authorizing your protected health information to be used and/or disclosed to the person(s) you list below.

- Discussion of financial account
- Discussion of medical status

- Discussion of scheduling appointments
- Other: Picking up Prescriptions

1) Name: _____ Relationship to patient: _____

2) Name: _____ Relationship to patient: _____

This authorization will expire when I have been discharged from Desert Pain Institute and all financial matters are settled.

I understand that I may revoke this authorization at any time by giving written notice to the front desk staff. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

Patient's Signature: _____ Today's Date: _____