



Desert Pain Institute
6309 E Baywood Ave
Mesa, AZ 85206
Office: 480-325-3801
Fax: 480-325-3805

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

I authorize the use and disclosure of the above named individual's health information as described below.

\_\_\_ This information may be released from Desert Pain Institute and sent to:

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_
Zip Code: \_\_\_\_\_
Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

\_\_\_ This information may be released to Desert Pain Institute from: Fill out facility name below.

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_
Zip Code: \_\_\_\_\_
Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

For the purpose of: \_\_\_ Further Medical Care \_\_\_ Disability \_\_\_ Legal \_\_\_ Personal Use \_\_\_ Insurance

\_\_\_ Please mail my records \_\_\_ Please fax my records \_\_\_ I will pick up my records

Information to be released:

\_\_\_ Complete Medical Records
\_\_\_ ASC
\_\_\_ Clinic OR \_\_\_\_\_ Dates of Treatment
\_\_\_ Rehab

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health services and treatment for alcohol and drug use. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Desert Pain Institute. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire automatically 1 year from the date on which it was signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date Date of Pick Up \_\_\_\_\_

For Office Use: Provider Requesting: \_\_\_\_\_