



HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____

My Authorization:

I authorize The Pain Experts of Arizona, PC, its agents and employees to use or disclose the following health information. Please check one of the boxes below:

- All of my health information
- My health information for the following condition(s): _____
- I do not authorize disclosure of my health information

The above party may disclose this health information to the following recipient(s), please include medical providers, family, and friends:

Name, relationship and/or organization:

My Rights

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.



- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign please complete the following:

Patient is a minor: _____ years of age

Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: Parent Legal Guardian Court Other: _____

Additional Consent for Certain Conditions: This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released

- I consent to have the above information released I do not consent to have the above information released

Signature of Patient or Authorized Representative: _____

Date: _____