PainX Advanced Pain Management & Spinal Intervention

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This authorization allows PainX Advanced Pain Management & Spinal Intervention to use or disclose your protected health information as described below. **You may revoke this authorization at any time** by writing to our Privacy Officer at the address listed below.

1. PATIENT INFORMATION

Patient's Name (Last, First, MI)	Date of Birth (MM/DD/YYYY)	Phone Number

2. AUTHORIZATION

☐ **I authorize PainX Advanced Pain Management & Spinal Intervention** to obtain my protected health information from any physician, hospital, health care provider, imaging center, laboratory, pharmacy, or other entity that has provided me medical care.

Provider(s), if known (optional): _____

3. INFORMATION TO BE USED OR DISCLOSED (Check all that apply)

☐ All Health Information (All Records) ☐ Office / Consultation Notes ☐ Imaging Reports

☐ Procedure / Operative Notes ☐ Medication List ☐ Billing / Claims Information

☐ Other (please specify): _____

4. DATES OF SERVICE

☐ All Dates

☐ Specific Dates: From _____

To _____

5. HOW SHOULD THE INFORMATION BE SENT?

☐ Fax to: _____

☐ Secure Email to: _____

☐ Mail

☐ Pick Up

☐ Other: _____

6. PURPOSE OF DISCLOSURE (Check one)

☐ Continued Medical Care ☐ Personal Use ☐ Attorney / Legal ☐ Insurance ☐ Other: _____

NOTICE OF RIGHTS

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address listed below. My revocation will be effective upon receipt, but will not be effective to the extent that PainX Advanced Pain Management & Spinal Intervention has already taken action in reliance upon this authorization.

I have a right to receive a copy of this authorization. I understand that information used or disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

This authorization expires one (1) year from the date signed below unless otherwise specified.

7. SIGNATURE

Signature of Patient or Legal Representative	Printed Name	Relationship (if not patient)	Date (MM/DD/YYYY)

4955 Van Nuys Blvd., Ste 505
Sherman Oaks, CA 91403 | (818) 444-4242 | (800) 448-2507 (fax) | PainXDoctors.com | painx@painxdoctors.com