Authorization to Disclose Health Information to Palo Verde Pain Specialists

*Patients Name:_____ * Date of Birth:_____

*I herebyauthorize _____

*Phone:_____ *Fax: _____

or its agent(s) to disclose my health information as described in this authorization to:

Palo Verde Pain Specialists
Office 833-578-7246
Fax 602-714-7176
13090 N 94th Drive, Suite 212
Peoria, AZ 85381

*The health information is being disclosed for the following purpose: (check appropriate box):

☐Change of Insurance or Physician ☐ Continuation of Care

*I understand I may revoke this Authorization at any time by sending written notice of my revocation to Palo Verde Pain Specialists health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event, or condition. If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

*I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

*I understand that Palo Verde Pain Specialists may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

***I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.**

_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative Date
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative and Telephone Number Relationship / Capacity to