THE Pain Center OF ARIZONA

Administrative Office
5281 N 99th Avenue, Suite 100
Glendale, AZ 85305-3105

Medical Records Dept
T: 623.241.6153 F: 623.241.6041

Patient Relations Dept
T: 623.516.8252 F: 623.516.8253

Authorization To Release Medical Information

Patient Information

Name: _____ Date of Birth: _____

Last 4 of Social Security #: _____ Telephone #: _____

Release Information from

I hereby authorize: ☐ The Pain Center of Arizona OR ☐ _____

Telephone #: _____ Fax #: _____

Release Information to

Name: _____

Street Address: _____

City / State / Zip: _____

Telephone #: _____ Fax #: _____

Information to be Released

☐ Dates of Treatment: _____

☐ Other: _____

I understand that my health information may be protected by federal privacy regulations. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facilities receiving it, and would then no longer be protected by federal privacy regulations.

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that I may revoke this authorization at any time except to the extent that The Pain Center of Arizona has already taken action in reliance upon it. I understand that in order to revoke this authorization, I must do so in writing and present my written notice to The Pain Center, Attn: Medical Records, 5281 N 99th Avenue, Suite 100, Glendale, AZ 85305. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization expires one year from the date of signature. A photocopy or scanned signature shall have the same force and effect as the original.

_____ _____

Signature of Patient or Patient Representative **Date**

If Patient Representative, description of their authority to act for the patient: _____

UNABLE TO PROCESS IF FORM IS INCOMPLETE – MUST BE SIGNED AND DATED