HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. This form is for use when 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:** _____

I. My Authorization

I authorize Arizona Pain Specialists, LLC, its agents and employees to use or disclose the following health information.

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

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

Name, relationship and/or organization _____

II. 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. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- 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.

DISCLAIMER: By typing your name below, you are signing this authorization electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

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: _____

DISCLAIMER: By typing your name below, you are signing this authorization electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Authorized Representative: _____ Date: _____

III. 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.

DISCLAIMER: By typing your name below, you are signing this authorization electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Patient or Authorized Representative: _____ Date: _____