HIPAA AUTHORIZATION

Disclaimer: This document is provided solely for reference purposes. Covered Entities under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I, (legal name) _____ DOB: _____**Phone Number**: _____

Please initial to give permission to COMPREHENSIVE PAIN SPECIALISTS to:

_____ Receive and release medical information/records from other entities as listed in section A
_____ Use the following protected health information
_____ Disclose the following protected health information as listed

Section A: Name of whom CPS can release your medical information to:

Family/Friend:_____Relationship:_____Phone:_____
PCP/Specialist:_____Phone:_____
Attorney/Law Firm **(required if you have a Lien or an open litigation case)**:_____
Phone:_____Address:_____

Section B: Pharmacy Information

_____

Section C: Laboratory (designated by Comprehensive Pain Specialists)

Section D: Information to be disclosed (check all that apply)

_____ Medical Records
_____ Treatment Records
_____ Diagnostic / Imaging Records
_____ Other: _____

Can confidential messages be left on your phone answering machine, voicemail and/or Email? Yes_____ No_____

Section E: Emergency Contact

Please list the family member or significant other, if any, whom we may inform about your medical condition in an EMERGENCY ONLY. *If not an emergency: Medical information including appointment information will not be released unless the name of the individual is listed above in section A.*

Name: _____ Phone: _____ Relationship: _____

This authorization expires 12 months from the signed date.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment.

You may inspect or receive a copy the Protected Health Information to be used or disclosed under this authorization. For Protected Health Information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

_____ _____
Signature of Patient or Personal Representative **Relationship to Patient**

_____ _____
Printed Name of Patient or Personal Representative **Date**