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:_____

Give Permission to COMPREHENSIVE PAIN SPECIALISTS to:

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

Section A: Name of whom Comprehensive Pain Specialists (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):**

Name:_____Phone:_____
Address:_____

Section B: Pharmacy Information:_____

Section C: Laboratory (designated by Comprehensive Pain Specialists)

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

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

Can confidential messages be left on your phone answering machine, voicemail and/or email? □ Yes □ No

This authorization expires 12 months from the date signed.

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 of 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**