Authorization to Release Health Information

Patient Name: ______________________________________ Date of Birth: _________________
Patient Address: ____
Phone #: ____

INFORMATION REQUESTED

I authorize the Bay Area Pain & Wellness Center to release the following health information during the term of this Authorization: (check all that apply)

☐ Complete Medical Record ☐ Surgical ☐ Hospitalization ☐ Billing Records ☐ Test Results (please specify) ____ ____	☐ Clinic Visit Notes ☐ Physical Therapy Notes ☐ History and Physical Exam ☐ Discharge Summary ☐ Other (please specify) ____ ____
For the following dates of treatment: (for example: specific date "1/25/07", "range of dates "Jan-July 2001", or "all dates available") Range of dates: ___________________________________to____________________________________	

RECIPIENT AND PURPOSE

If the information is not being delivered to me, then deliver my health information to: (for example: physician, insurance company, school, attorney, etc.)

Name of Person:	Phone Number:
Name of Organization:	
Street Address:	
City, State, Zip	
The purpose of the disclosure is (check those that apply): ☐ Continuity of care or discharge planning ☐ Billing and payment of bill ☐ At the request of the patient/patient representative ☐ Other (state reason) ____	

SPECIFIC CONSENT

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- ☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et seq.).
- ☐ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- ☐ Release of genetic testing information (Health and Safety Code §120980(j)).
- ☐ Psychotherapy notes

15047 Los Gatos Blvd. #200 Los Gatos, CA 95032 phone 408.364.6799 fax 408.378.4510
1050 Northgate Drive #460 San Rafael, CA 94903 phone 415.461.7246 fax 415.461.2476
700 Frederick St. #301 Santa Cruz, CA 95062 phone 408.364.6799 fax 408.378.4510

EFFECTIVE DATE OF AUTHORIZATION

This authorization will remain in effect under the following conditions: (check one preference)

☐ From the date of this Authorization until the following date: ______________________________

☐ Until the purpose is fulfilled.

☐ Until the following event occurs: ____

☐ Other: ____

Note: The term for mental health records must be stated – you may not use "no expiration." If no termination event is filled in, then this Authorization will expire on the end of business day of the date signed below.

AUTHORIZATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure outlined. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

The Bay Area Pain & Wellness Center and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that once my health information is disclosed to the recipient, the Bay Area Pain & Wellness Center cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.

I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with eligibility or enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

I may revoke this authorization at any time, provided that I do so in writing and submit to the Bay Area Pain & Wellness Center, 15047 Los Gatos Blvd., #200, Los Gatos, CA 95032. The revocation will take effect when the Bay Area Pain & Wellness Center receives it, except to the extent that the Bay Area Pain & Wellness Center or others have already relied on it.

I am entitled to receive a copy of this Authorization.

I have read and understand this Authorization and had a chance to ask questions about the disclosure of the health information. I authorize the Bay Area Pain & Wellness Center to use/disclose my health information in the manner described above.

______________________________________ ______________________________

Signature of Patient or Personal Representative Date

______________________________________ ______________________________

Name of Personal Representative* (if applicable) Relationship to Patient

*The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.

______________________________________ ______________________________

Treating Physicians Signature Date