



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)

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Clinic Visit Notes
<input type="checkbox"/> Surgical	<input type="checkbox"/> Physical Therapy Notes
<input type="checkbox"/> Hospitalization	<input type="checkbox"/> History and Physical Exam
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Test Results (please specify)	<input type="checkbox"/> 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):	
<input type="checkbox"/> Continuity of care or discharge planning	<input type="checkbox"/> Billing and payment of bill
<input type="checkbox"/> At the request of the patient/patient representative	
<input type="checkbox"/> Other (state reason) _____	

SPECIFIC CONSENT

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

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



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