ADVANCED PAIN MANAGEMENT

MEDICAL RECORDS AUTHORIZATION OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

I hereby authorize (place medical records are wanted from) _____

_____

to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following PHI:

Category of PHI

☐ Medical Records ☐ Claims/Billing Information ☐ Mental Health Records

☐ Drug/Alcohol Abuse ☐ HIV Test Results ☐ MRI and X-ray Records

Amount of PHI

☐ Entire PHI in the chosen category (Example—All "HIV test Results")

☐ Please limit use and disclosure of my PHI to:

_____

(Examples—"Laboratory results from July 2020"; "Mental health records from January 2020 to present")

The recipient of my PHI:

☐ Ravi Panjabi, M.D.

☐ Ramesh Singa, M.D.

☐ 19850 Lake Chabot Rd, Castro Valley, CA 94546 (P) 510-582-8555 (Fax) 510-581-8686

☐ 1081 Market Place, # 100, San Ramon, CA 94583 (P) 510-582-8555 (Fax) 510-581-8686

☐ 1860 Mowry Avenue, Suite 201, Fremont, CA 94538 (P) 510-582-8555 (Fax) 510-581-8686

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

☐ Parent, guardian or caregiver of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of a deceased patient

☐ (Spouse, etc.) _____ (SPECIFY RELATIONSHIP)