bostonpaincare

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Full Name: ______________________________ Date of Birth: ______________

Address: ____

Phone #: ______________________________ Work Phone #: ______________

Email Address: ______________________________ Cell Phone #: ______________

Preferred Method of Delivery: ☐ MAIL ☐ FAX SEX: M / F Marital Status: ______________

I hereby authorize Boston PainCare, Boston Surgery Center, and Boston SleepCare to release or disclose my protected health information:

☐ To Myself (same as above) OR ☐ As Indicated Below

Name: ______________________________ Daytime Phone #: ______________

Address: ______________________________ Fax #: ______________

Information to be released:

☐ All ☐ Selected Info From & To Dates: ______________________

☐ Diagnostic Imaging	☐ Functional Rehabilitation	☐ Injection / Procedure Notes
☐ Lab Work	☐ Medical Evaluations / Consultations	☐ Medication Management
☐ Neurology	☐ Physiatry	☐ Sleep

Purpose of Disclosure

☐ At my (patient) request	☐ Changing Providers / Discontinuing Care	☐ Legal
☐ Insurance	☐ Second Opinion	☐ Work Related
☐ Workman's Compensation	☐ Other ______________________	

I understand that I may revoke this authorization at any time by notifying Rachel Porter, Privacy Officer, in writing. Submitting a **written request** will terminate the authorization, unless it has already been acted upon.

By signing below, I have acknowledged that I have read and understand this authorization.

______________________________ ______________

Patient / Legal Guardian Signature Date:

If legally acting on behalf or guardian for patient, copy of legal documentation required.