Pacific Spine & Pain Center
INNOVATIVE SOLUTIONS FOR PAIN™

Brandon N. Sorensen, M.D. Pain Management Specialist
805 West Acequia Ave, Suite 1-D Visalia, CA 93291
office # 559.713.6515 fax # 559.713.6516

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize _____

To use and disclose a copy of the specific health and medical information described below regarding: _____

_____
Patient Name Date of Birth

Consisting of _____
Describe information to be used/disclosed

To: _____.
Name, fax, phone, and address of recipient or class of recipients

For the purpose of: _____
Describe each purpose of disclosure or indicate that disclosure is at the request of the individual

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___HIV/AIDS information
___Mental health information
___Genetic testing information
___Drug/alcohol diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make this disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to Medical Records Department at Pacific Spine and Pain Center, 805 W Acequia Ave, Suite 1-D Visalia, CA 93291 and state that you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. Unless revoked, this authorization expires (insert either applicable date or event): _____or after 90 days from signature.

Patient Signature: _____ Date: _____

- OR -

Patient Representative Signature: _____ Date: _____

Description of Representative's Authority: _____