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Coastal Pain and Spinal Diagnostics Medical Group

6221 Metropolitan St., Suite 201 Carlsbad, CA 92009 / 4910 Directors Pl., Suite 330 San Diego, CA 92121
Phone: (760) 753-7127 Fax: (760) 683-3270 www.CoastalPainGroup.com

Authorization for Use/Disclosure of Health Information:

Name: ______________________________ **Date of Birth:** ____ / ____ / ______

Last First Middle MM / DD / YYYY

<u>Authorization for use/disclosure of information:</u> I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the Recipient that I have identified below.

<u>Provider's Name and Address for Release of Records:</u>

Name: ______________________________

Address: ______________________________

____

Fax: ______________________________

Phone: ______________________________

<u>Recipient and Address for Delivery of Records:</u>

Name: Coastal Pain & Spinal Diagnostics Inc.
Address: 6221 Metropolitan Street, Suite 201
Carlsbad, CA 92009
Fax: (760) 334-0399

<u>Purpose:</u> I understand that the specific purpose of this authorization is:

____

<u>Information to be disclosed:</u> This authorization permits the above named healthcare provider to Disclose the following medical records: ______________________________

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

☐ All of my health information described above except the following:

____

☐ Only the following records or types of health information (Insert dates of treatment, types of treatment or other designation):

____

Term: This authorization will remain in effect for one (1) year from the date this authorization is signed.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at anytime) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of revocation.

Questions: I may contact my provider's office for answers to my questions about the privacy of my health information. I understand that I have the right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax of electronic copy of this authorization shall be considered as effective and as valid as the original.

Signature	**Date**
Signature of Witness	**Date**

Name: ______________________________
(Please Print)

If individual is unable to sign this authorization, please complete the information below:

Signature of Personal Representative	**Legal Relationship**	**Date**
Signature of Witness	**Date**	

Name: ______________________________
(Please Print)