San Diego
Pain Management

Specific Authorization for Use/Disclosure of Health Information:

Name:_____ Date of Birth:_____
Last, First Middle

I voluntarily authorize and direct that my confidential healthcare information be disclosed either by sharing written records or by phone conversation. (Check one box. "Both" is easiest for us, meaning that either party may send records. Note that our standard practice is not to request any written records from mental health providers).

To: ☐ From: ☐ **Both** To and From: ☐

with:

Provider's Name and Address for Release of Records:

Name of Provider or Practice:_____

Telephone:_____ Fax:_____

Address:_____

_____

San Diego Pain Management Contact Information:

Facsimile: 858-431-4633

Telephone: 858-454-5442

email: mail@SDPainMgmt.com

Address: 9850 Genesee Avenue Suite 820, La Jolla, CA 92037-1219

☐ I authorize my providers from the two organizations to discuss my care directly.

Information to be disclosed:

☐ All 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, psychotherapy notes, other mental health information, drug, alcohol, or other controlled substance information, billing information, correspondence, and records from my other healthcare providers that the above-named healthcare provider may hold.

☐ All of the above, except the following:_____

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Term: Unless otherwise stated, this authorization will remain in effect for one year from the date this authorization is signed.

Refusal to sign/right to revoke: I understand that I may refuse to sign, or at any time may revoke this authorization for any reason. However, it is the general policy of this practice that the pain management specialist be able to communicate freely with other treating providers, and also be able to obtain records from prior treating pain specialists, both necessary to provide the highest quality of medical care.

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

Patient Signature: _____ Date:_____

If patient is unable to sign this authorization, please complete the information below:
Signature of Personal Representative:_____ Date:_____
Name:_____
Legal Relationship to Patient:_____