

AZ PAIN DOCTORS

Biltmore Location: 2222 E Highland Ave Ste#220, Phoenix, AZ 85016
Casa Grande Location: 1760 E Florence Blvd Ste#140, Casa Grande, AZ 85122
Chandler Location: 725 S Dobson Rd Ste#100, Chandler, AZ 85224
Glendale Location: 7200 W. Bell Rd, Ste#F101, Glendale, AZ 85308
Mesa Location: 1950 S Country Club Dr Ste#102, Mesa, AZ 85210
North Scottsdale Location: 33747 N. Scottsdale Rd, Ste#135, Scottsdale, AZ 85266
Goodyear Location: 1325 N Litchfield Rd Ste#120, Goodyear, AZ 85395
Paradise Valley Location: 10565 N Tatum Blvd Ste#B116, Paradise Valley, AZ 85253
Sun City West: 14420 W Meeker Blvd Ste#211, Sun City West, AZ 85375
Office: 602-795-8700 Fax: 602-795-8701

AUTHORIZATION FOR AZ PAIN DOCTORS TO DISCLOSE HEALTH INFORMATION

*Patient Name: _____ *Date of Birth: _____

*Phone Number: (_____) _____

I authorize AZ Pain Doctors to disclose the following health information of mine to the following Recipient:

***Health information to be disclosed: (check appropriate box)**

2 years prior from last date seen by AZ Pain Doctors

The following health information (be specific): _____

***Recipient of health information:**

If the recipient is intended to be the undersigned patient (yourself), please specify how you would like to receive records: **Name:** _____ **Phone:** (_____) _____

Fax (_____) _____

Mail _____ City _____ State _____ Zip _____

I will pick them up from the office

***Please note requests with incomplete information may not be processed.**

***The health information is being disclosed for the following purpose: (check appropriate box):**

Change of Insurance or Physician

Continuation of Care

At the undersigned Patient's request

The following purpose (be specific): _____

*I understand I may revoke this Authorization at any time by sending written notice of my revocation to AZ Pain Doctors health information management department. I understand that my revocation will not be effective to the extent AZ Pain Doctors has taken action in reliance on this Authorization.

*Unless revoked sooner, this Authorization will expire on the following date, event, or condition _____. If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

** I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.*

*I understand that AZ Pain Doctors may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal privacy regulations.

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.

X _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

_____ Date

Printed name of Authorized Representative and Telephone Number

Relationship / Capacity to Patient