AZ PAIN DOCTORS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO AZ PAIN DOCTORS

***Patients Name:____* Date of Birth:______________________**

***I hereby authorize ____**

*** Phone:________________________________ * Fax:______________________________________**

or its agent(s) to disclose my health information as described in this authorization to AZ Pain Doctors
Office 602-795-8700 Fax 602-795-8701

***Choose Physicians Location**
__Biltmore: 2222 E Highland Ave Ste#220, Phoenix, AZ 85016
__Casa Grande: 1760 E. Florence Blvd #120, Casa Grande, AZ 85122
__Chandler: 725 S. Dobson Rd, Ste#100, Chandler, AZ 85224
__Glendale: 7200 W. Bell Rd, Ste#F101, Glendale, AZ 85308
__Goodyear: 1325 N Litchfield Rd Ste#120, Goodyear, AZ 85395
__Mesa: 1950 S Country Club Lane Ste#102, Mesa, AZ 85210
__North Scottsdale: 33747 N. Scottsdale Rd, Ste#135, Scottsdale, AZ 85266
__Paradise Valley: 10565 N Tatum Blvd Ste#B116, Paradise Valley, AZ 85253
__Sun City West: 14420 W Meeker Blvd Ste#211, Sun City West, AZ 85375

***The health information is being disclosed for the following purpose: (check appropriate box):**
☐ Change of Insurance or Physician ☐ Continuation of Care

***Health information to be disclosed: (check appropriate box)**
☐ 2 years prior from last date seen by the healthcare provider ☐ The following health information (be specific):

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*I understand I may revoke this Authorization at any time by sending written notice of my revocation to AZ Pain Doctor's health information management department. I understand that my revocation will not be effective to the extent the healthcare provider 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 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 redisclose 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 Date

(Guardian or Authorized Representative must attach documentation of such status.)

____ ________________________

Printed name of Authorized Representative and Telephone Number Relationship / Capacity to