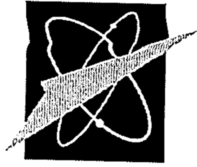

S. Vengurlekar, MD,
7010 E. Chauncey Lane Suite 215
Phoenix, AZ 85054
Phone: 480-314-2288
Fax: 480-314-2288

Patient Authorization to Use or Disclose Protected Health Information

HIPAA Privacy Rules require we obtain your authorization when disclosing protected health information for reasons other than payment, treatment, healthcare operations or special circumstances under applicable laws. Please complete the below information to provide authorization for the release of protected health information.

Patient Name:____________________ **Date of Birth:**____________

Phone Number:____________________

Information to include:

☒ My health information for the last three months (i.e. initial consult, follow-ups, imaging, etc).

☐ My health information regarding the following condition(s):____________________

☐ My health information for the following date(s):____________through____________

☐ Other:____

The health information described above may be used or released to: check

☐ **Premier Pain Institute:** Fax: 480-314-1113

OR

☐ Practice Name: ____________________ Physician Name:____________________

Address:____

Phone:____________________ Fax:____________________

This authorization is effective until revoked, or terminated in writing by the patient, or patient's representative. Otherwise this authorization will end on: ____________________

Please describe the purpose, or intended use of the requested information:____________

____

Patient/Patient's Representative Name:____________________

Patient/Patient's Representative Signature:____________________

Relationship to patient:____________________________