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# Coastal Pain and Spinal Diagnostics Medical Group

6221 Metropolitan St., Suite 201 Carlsbad, CA 92009
(760) 753-7127    www.CoastalPainGroup.com

## *Authorization for Use/Disclosure of Health Information:*

***Name***: ________________________________    ***Date of Birth:*** ____/______/_____

***Authorization for use of information*: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization is the recipient that I have identified below.**

***Provider's Name and Address for Release of Records:***
**Name: Coastal Pain & Spinal Diagnostics Inc.**
**Address: 6221 Metropolitan Street, Suite 201**
**Carlsbad, CA 92009**
**Fax: (760) 334-0399**

***Recipient and Address for Delivery of Records:***

***Name:*** ________________________________________

***Address:*** ________________________________________

________________________________________

***Fax:*** ________________________________________

***Phone:*** ________________________________________

***Purpose: I understand that the specific purpose of this authorization is:***

________________________________________________________________

***Information to be disclosed" This authorization permits the above named healthcare provider to disclose the following medical records***:
________________________________________________________

- ☐ **All of my information that the provider has in his/her possession, including information relating to any and all 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 healthcare providers that the above named healthcare providers may hold.**
- ☐ **All of my health information described above except the following**

## *Authorization for Use/Disclosure of Health Information (Continued):*

☐ **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 any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my healthcare 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 healthcare provider at my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare 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 healthcare 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)***

Updated: 04/28/2015