Nathan Miller, MD | Yogesh Patel, MD | Ankush Bansal, MD | Evan Goodman, MD

Coastal Pain & Spinal Diagnostics

6221 Metropolitan St., Suite 201 Carlsbad, CA 92009
2020 Camino Del Rio N, Suite 805, San Diego, CA 92108
Phone: (760) 753-7127 Fax (760)334-0399
www.CoastalPainGroup.com

Authorization for Release/Request of Health Information

Patient Name: ____ Date of Birth: ____/______/_____

Authorization for use of Health information *(Select one of the following)*

☐ I authorize the record holder named below to release my health records to **Coastal Pain & Spinal Diagnostics Medical Group, Inc.** during the term of this authorization.
Mail to: 6221 Metropolitan Street, Suite 201, Carlsbad, CA 92208 or Fax to: (760) 334-0399

☐ I authorize Coastal Pain & Spinal Diagnostics Medical Group, Inc. to release my records to the provider/group/person (circle one) listed below during the tern of this authorization

Current Records Holder or Requestor of Records:

Name: ____ Tel. (____) ___________ Fax (____) _________

Address: ____ State ________ Zip Code ____________

This authorization permits the above-named healthcare provider to disclose/request 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 my health information described above except the following ____
____

☐ 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.

Print Name: _______________________________ Sign ____________________________ Date: ____________

Witness Name: _____________________________ Sign ____________________________ Date: ____________

If individual is unable to sign this authorization please complete the following

Signature of personal representative _______________________Relationship: ________________Date: ____________

Witness Name: _____________________________ Sign ____________________________ Date: ____________