



Authorization for Release of Protected Health Information

Patient Name: _____
Address: _____

Other Name: _____
Birth date: _____
Soc. Sec. No.: _____
Phone (Day): _____

I hereby authorize _____

to release a copy of the following information:

To: Apex Pain Specialists, P.C.
2705 S. Alma School Road, Suite 1
Chandler, AZ 85286
Phone: (480) 820-7246 Fax: (480) 897-7246

- For the following purposes: _____
 At my request

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I do do not authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

Patient or Personal Representative's Signature

Date

Description of Representative's Authority to Act for Patient

This authorization will expire on _____ (list date or event).