MISSION
advanced pain management & spine center

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION:

I hereby authorize: _____
Physician/Healthcare Facility

Phone : _____
Fax : _____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: **Mission Advanced Pain Management & Spine Center's provider(s)**

Address: P.O. Box 2278
Mission Viejo, CA 92690 - 2278
Phone : (949) 441- 5445 Fax: (949) 441- 5450
Email : info@abovepain.com

This authorization is:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV, Diagnosis/ Treatment)

☐ Limited to the following medical information:

_____

_____

I also consent to the specific release of the following records:

- Drug/Alcohol/Substance Abuse _____(initials)
- HIV Diagnosis/Treatment_____(Initials)
- Genetic Information _____(Initials)
- Psychiatric/Mental Health _____(Initials)
- Tests for Antibodies to HIV _____(Initials)

DURATION:
This authorization shall be effective immediately and remain in effect until _____(Date)

*****For No duration date specified, the form will remain valid for one (1year from the signature date below - Recommended *****

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Signature of Patient (or legal/personal representative) _____

Patient's Name (please print) _____

Patient's Social Security Number _____

Patient's Date of Birth _____

Witness Name _____

Relationship (if other than patient) _____

Witness Signature _____

Today's Date _____