**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last First Middle

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, FL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MY HEALTH INFORMATION TO BE DISCLOSED:**

By signing this authorization, I authorize Riverside Pain Physicians to disclose the following

health information about me:

🞏A copy of my entire medical record and any other health information about me maintained by Provider.

🞏Other (Please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MY SENSITIVE INFORMATION TO BE DISCLOSED**:

By checking any of the boxes below, I specifically authorize the Provider to use and disclose the

type of information indicated next to the box pursuant to this authorization:

🞏Information about mental health services

🞏Information about HIV/AIDS testing or treatment (including the fact that an HIV test was

ordered, performed or reported)

🞏Information about sexually transmitted diseases

🞏Information about alcohol or drug abuse treatment program services

🞏Information about DNA analysis or other genetic test results or information

**RECIPIENT:** Name of person or class of persons who may receive my health information from

the Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address of the Recipient or delivery location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TERM:** This authorization will remain in effect:

🞏From the date of this Authorization until \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_, 20\_\_\_\_\_

🞏Until the Provider fulfills this disclosure request

🞏Until the following event occurs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE**: The Provider is authorized to use or disclose my health information identified

above to the Recipient for the following specific purpose(s): (“At the request of the patient” is

sufficient if the patient is initiating this authorization):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that once the Provider discloses my health information to the Recipient, the

Provider cannot guarantee that the Recipient will not re-disclose my health information to a third

party. Any third party may not be required to abide by this Authorization or applicable federal

and state law protecting the privacy of my health information. I understand that the Provider will

not receive remuneration from a third party for the use or disclosure of my health information.

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 the Provider’s treatment of me.

I understand that this Authorization will remain in effect until the term of this Authorization

expires or I provide a written notice of revocation to the Provider at the address listed below. The revocation will be effective immediately upon the Provider’s receipt of my notice of revocation, except that the revocation will not have any effect on any use or disclosure of health information or other action taken by the Provider in reliance on this Authorization before it received my notice of revocation.

If I have questions or wish to revoke this authorization, I may contact:

Monica Aliberti

Vice President of Physician Practice Operations

813-872-4492

I have read and understand this Authorization and I have had an opportunity to ask questions

about the use and disclosure of my health information. By my signature below, I hereby,

knowingly and voluntarily, authorize the Provider to use or disclose my health information

(including the specified categories of my sensitive information) in the manner described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_, 20\_\_\_\_\_\_

Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

authorize the Provider to use or disclose the patient’s health information (including the specified

categories of sensitive information) in the manner described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_, 20\_\_\_\_\_\_

Signature of Personal Representative Description of Date

Authority