NEVADA PAIN
WE CHANGE LIVES HERE
a Pain Doctor Company

For practice locations please visit www.nevadapain.com

AUTHORIZATION FOR NEVADA PAIN TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Phone Number: (_____) _____

I authorize Nevada Pain (NP) to disclose the following health information of mine to the following **Recipient:**

Health information to be disclosed: (check appropriate box)
☐ 2 years prior from last date seen by NP
☐ The following health information (be specific): _____
_____

Recipient of health information:
If the recipient is intended to be the undersigned patient (yourself), please specify how you would like to receive records:

Name: _____ **Phone:** (_____)_____
☐ Fax (_____)_____
☐Mail _____City_____ State_____ Zip_____
☐ I will pick them up from the office
☐ Patient Portal (NP Staff: Ensure patient has Patient Portal account initiated)

Please note requests with incomplete information may not be processed

The health information is being disclosed for the following purpose: (check appropriate box):
☐ Change of Insurance or Physician
☐ Continuation of Care
☐ At the undersigned Patient's request
☐ The following purpose (be specific): _____

- I understand I may revoke this Authorization at any time by sending written notice of my revocation to NP's health information management department. I understand that my revocation will not be effective to the extent NP has taken action in reliance on this Authorization.
  Unless revoked sooner, this Authorization will expire on the following date, event, or condition_____.
  If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.
- I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.
- I understand that NP may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal privacy regulations.

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.

X_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative — Date
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative and Telephone Number — Relationship / Capacity to Patient