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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

_____ Patient Name	_____ Contact Number	_____ Date of Birth
Authorizes: <u>Nevada Advanced Pain Specialists</u> Name of Healthcare Provider/Plan/Other	Release To: _____ Name of Healthcare Provider/ Plan/ Other	
<u>5578 Longley Lane Reno, NV. 89511</u> Address	_____ Address	
<u>775-284-8650</u> Phone/ Fax	_____ Phone/ Fax	

Information to be released.

entire record physical therapy billing
 progress note lab results other: _____
 procedure notes imaging

Dates of service: _____ to _____

Reason for Disclosure: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. . A copy, electronic copy, image, or facsimile of this authorization is as valid as the original.

I understand that the person(s) and/or organization(s) above that I am authorizing to use/disclose my information may not condition my treatment, payment, or eligibility for healthcare benefits on my decision to sign this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

This authorization is valid for 12 months following the date of my signature shown below.

Signature of Patient or Representative

Date

Relationship to Recipient