bostonpaincare

85 First Avenue, Waltham, MA 02451
(781) 647-7246 FAX: (781) 290-0720 www.bostonpaincare.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Full Name: _____ Date of Birth: _____

Address: _____

Phone #: _____ Work Phone #: _____

Email Address: _____ Cell Phone #: _____

Preferred Method of Delivery: ☐ MAIL ☐ FAX SEX: M / F Marital Status: _____

I hereby authorize Boston PainCare and Boston Surgery Center to release or disclose my protected health information:

☐ To Myself (same as above) OR ☐ As Indicated Below

Name: _____ Daytime Phone #: _____

Address: _____ Fax #: _____

Information to be released:

☐ All ☐ Selected Info From & To Dates: _____

☐ Diagnostic Imaging ☐ Functional Rehabilitation ☐ Injection / Procedure Notes

☐ Lab Work ☐ Medical Evaluations / Consultations ☐ Medication Management

☐ Neurology ☐ Physiatry ☐ Sleep

Purpose of Disclosure

☐ At my (patient) request ☐ Changing Providers / Discontinuing Care ☐ Legal

☐ Insurance ☐ Second Opinion ☐ Work Related

☐ Workman's Compensation ☐ Other _____

I understand that I may revoke this authorization at any time by notifying Erin Kotwicki, Privacy Officer, in writing. Submitting a **written request** will terminate the authorization, unless it has already been acted upon.

By signing below, I have acknowledged that I have read and understand this authorization.

_____ _____

Patient / Legal Guardian Signature Date:

If legally acting on behalf or guardian for patient, copy of legal documentation required.