SPECIALTY PAIN MANAGEMENT CENTER

AJAY M. NARWANI M.D., PLLC

DIPLOMATE IN ANESTHESIA, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE IN PAIN MEDICINE, AMERICAN BOARD OF ANESTHESIOLOGY

HIPAA Privacy Rights Form

PATIENT INFORMATION

_____
Date

_____ _____ _____
Name (Last, first, middle initial) DOB Social Security # or Patient ID

_____ _____ ____ _____
Street address City State ZIP Code

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED……

☐ MEDICAL RECORDS ☐ TEST RESULTS ☐ APPOINTMENTS
☐ PHONE MESSAGES ☐ MEDICATION INFORMATION ☐ ALL INFORMATION

I authorize to release one or all of the above information to the following persons……

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

Please list the following for Specialty Pain Management to leave confidential information.

_____ _____ _____
Primary phone number Other phone number E-mail address

_____ I DO NOT authorize any medical information to be released to any other individuals

Signature _____ Date _____

No information will be released to any persons without the permission of the patient. All authorized persons receiving any information will need to show proper identification before any information will be released.