SPECIALTY PAIN MANAGEMENT
Treating Your PAIN With Compassion

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 Specialty Pain Management to leave confidential information on my provided home/cell phone, answering machine/voicemail and/or email

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

I authorize Specialty Pain Management (providers and staff) permission to discuss and/or disclose my health information with the following person/persons listed below:

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

_____ **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. HIPAA Privacy Rights Form