AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION FROM MIND AND BODY PAIN CLINIC

Patient Name:
Social Security Number:
Date of Birth:
Telephone:

I hereby authorize:
MIND AND BODY PAIN CLINIC
6010 Hellyer Ave., Suite 150 San Jose, CA, 95138
Phone:(408) 356-5900 Fax: (408) 356-5902

To disclose to:
Name of Receiving Party _____
Address _____
City _____ State_____ Zip _____
FAX _____

I understand that the health care provider or health plan identified above may not condition treatment, payment, enrollment or eligibility for benefits upon my signing this authorization.

DURATION: This authorization shall become effective immediately and shall remain in effect until or for one year from the date of signature.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of information is to be disclosed:

[ ] MEDICAL/HEALTH INFORMATION [ ] PSYCHIATRIC INFORMATION

[ ] DRUG/ALCOHOL INFORMATION [ ]RESULTS OF AN HIV BLOOD TEST

[ ] OTHER HEALTH INFORMATION (Specify below):

The requester may use the health information authorized on this form for continuity of Care.

Signature: _____ Date: _____