CENTER FOR
WELLNESS & PAINCARE
OF LAS VEGAS
"where healing begins..."

AUTHORIZATION FOR THE CENTER FOR WELLNESS AND PAIN CARE TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB _____

Phone number: (_____)_____

I authorize The Center for Wellness and Pain Care to disclose the following health information of mine to the following Recipient:

Health information to be disclosed: (check appropriate box.

____ 2 years prior form last date seen by this office

_____ The following health information (be specific): _____

_____

Recipient of health information:

If the recipient is intended to be the undersigned patient (yourself), please specify how you would like to receive records

1) Name:_____ Phone (_____)_____

2) Fax to (_____)_____

3) Mail to Address: _____ City_____State _____Zip_____

4) I will pick them up from the office

Please note requests with incomplete information may not be processed

The health information is being disclosed for the following purpose: (check appropriate box):

___ Change of Insurance or Physician

___ At the undersigned Patient's request

___ Continuation of Care

___ For the following purpose (be specific) _____

- I understand I may revoke this Authorization at any time by sending written notice of my revocation to The Center for Wellness and Pain Care (CWPC). I understand that my revocation will not be effective to the extent the CWPC has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date date, event, or condition _____. If no date, event, or condition is written, this authorization will expire 1 year from the date signed A photo copy of this Authorization will be considered effective and valid as the original
- I understand that the health information authorized to be disclosed under this Authorization may include information regarding drugs or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.
- I understand that CWPC many not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the recipient may redisclose the records and that the records may no longer be protected by Federal Privacy Regulations.

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions

X

_____ _____

Signature of Patient/Parent/Guardian or Authorize Representative Date

_____ _____

Printed name of Authorized Representative and Telephone number Relationship/Capacity to Patient