AUTHORIZATION TO RELEASE RECORDS TO THE CENTER FOR WELLNESS AND PAIN CARE

Patient Name: ____ Date of Birth: ___________________

I hereby authorize ____

Phone: ____ Fax: ____

or its agent(s) to disclose my health information as described in this authorization to:

The Center for Wellness and Pain Care

311 North Buffalo Suite A

Las Vegas, NV 89145

F: 702 476-9138 P: 702 476-9700

Health information to be disclosed: (Check Appropriate line)

__ 2 years prior from last date seen by the healthcare provider ___ The following health information (be specific):

____

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

___ Change of Insurance or Physician ___ Continuation of Care

- 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. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event or condition: _________________________________

If no date, event or condition is written, this authorization will expire 1 year from the date signed. A photocopy 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 drug 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 The Center for Wellness and Pain Care may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal Privacy Regulations.

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

____ ________________

Signature of Patient/Parent/Guardian or Authorize Representative Date

(Guardian or Authorized Representative must attach documentation of such status)

____ ______________________

Printed name and Telephone number Relationship