85 First Avenue
Waltham, MA 02451

Authorization for Use or Disclosure of Health Information

Name____

Date of Birth________________ SS#__________________

Daytime Phone #_______________________ Cell OR Other_________________

Address ____________________________________

City _____________ Sate______________ Zip Code______________

I hereby authorize Boston **PainCare Center, Boston Surgery Center**, and **Boston Sleep Center** to use or disclose my protected health information as indicated below:

Name____

Daytime Phone________________________ Fax_________________

Address__________________________

City ___________________________ State_____________ Zip Code__________

Information to be released:

From & To Dates____________ All______

___ Physical Performance Measurement Test (Don Counihan) ___ X-Ray, MRI, CT ____ Injection Notes ___ Sleep Notes

___ Med. Management ___ Physical Therapy Notes _____ Dr. Dhar

Purpose of Disclosure:

___Changing physicians ___ Second Opinion ___Continuing care ___ Legal ___ At my (patient) request ___ Insurance

___Worker's Compensation ___ School Other______________________________

1. I understand that I may revoke this authorization at any time by notifying **Rachel Porter**, Privacy Officer, in writing. Submitting a written request will terminate this authorization, unless it has already been acted upon.
2. I understand that my private health information will no longer be protected by federal privacy regulations. However, federal law prohibits disclosing specially protected information, such as substance abuse treatment, HIV/AIDs-related, and psychiatric/mental health information.
3. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization

_______________________________ _______
Signature of Patient Date

For Office Use Only

Date Request Filled _____________ by _________________________ Chart #_____________ Fee $_________