SPINE & PAIN MANAGEMENT

AUTHORIZATION FOR RELEASING HEALTH INFORMATION

NAME: Last _____ First _____

LAST 4 SSN: _____ **DATE OF BIRTH:** _____ / _____ / _____ **PHONE NUMBER:** (_____) _____-_____

I hereby authorize that Keeran Kumar, M.D. may obtain OR release the protected health information regarding the above named person to be used in treatment and diagnosis by Interventional Spine and Pain Management as well as any health provider authorized by the treating physician. I understand that this may include referrals, medical records, and radiology reports relevant to treatment.

I understand that records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION OF DISCLOSURE: Alcohol and drug abuse information, if present has been disclosed from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits recipients from making any further disclosure of this information except with specific written consent to the patient. DIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by state Regulations without the specific written consent of the patient. A general authorization for the release of information if held by another Party is not sufficient for this purpose.

RE-DISCLOSURE: Notice is hereby given to the patient of legal representative signing this authorization that Keeran Kumar, M.D. cannot guarantee that the recipient receiving the requested health information will not re-disclose it to others. Notice is hereby given to the recipient that law prohibits the re-disclosure of any health information regarding drug and or alcohol abuse, DIV and mental health treatment.

EXPIRATION:
Without my expressed revocation, the authorization will automatically expire upon satisfaction of the need for disclosure.

PATIENT SIGNATURE: _____ **DATE SIGNED:** _____ / _____ / _____

OFFICE USE ONLY

DATE OF REQUEST: _____ / _____ / _____

PURPOSE: Information is to be used by Keeran Kumar, MD for:

☐ TREATMENT/RECORDS ☐ BENEFITS ☐ LEGAL ☐ OTHER:

ADDRESS/FACILITY OF REQUESTED INFORMATION: _____

_____

PHONE: (_____) _____-_____

FAX: (_____) _____-_____

NOTES: