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Paradise Valley Pain Specialists

Paul Wang, D.O.
Fellowship-trained in Pain Management
Board-certified in Physical Medicine & Rehabilitation

Authorization For Use And Disclosure Of Protected Health Information

Patient Name: _____ DOB: _____

The information covered by this authorization includes only those items marked:

Patient Medical Evaluation and Treatment Notes	❑ ALL	❑ From: _____	❑ To: _____
Laboratory Testing and Diagnostic Studies	❑ ALL	❑ From: _____	❑ To: _____
X-Ray, MRI, CT, and Any Other Imaging Studies	❑ ALL	❑ From: _____	❑ To: _____
Mental Health Diagnosis and Treatment	❑ ALL	❑ From: _____	❑ To: _____

I AUTHORIZE:

_____

Name Of Company, Hospital, Physician or Person Authorized to Send Records

Address: _____

City State Zip

Phone: _____ Fax : _____

TO SEND/RELEASE/DISCLOSE ABOVE INDICATED MEDICAL INFORMATION TO:

_____

Name Of Company, Hospital, Physician or Person Authorized to Send Records

Address: _____

City State Zip

Phone: _____ Fax : _____

This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

You may revoke or terminate this authorization by submitting a written revocation to Paul Wang, D.O.

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____

Signature of Patient / Guardian / or Patient Representative Date