Addison
Pain & Regenerative Medicine
16633 DALLAS PKWY SUITE 150 ADDISON, TX 75001

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Addison Pain and Regenerative Medicine ("APRM") recognizes the patient's right to confidentiality of protected health information ("PHI"). This form obtains permission to discuss and/or release information regarding your care at our practice to a person whom you designate as an authorized representative. Authorization is optional- you may opt to not designate any authorized representatives.

Please bear in mind, if you intend for anyone else to schedule your appointments, manage your prescriptions, or receive billing/account/medical record information on your behalf, you must authorize them on this form.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I AUTHORIZE APRM TO DISCLOSE MY PHI TO THE LISTED PERSON(S):

NAME:	PHONE NUMBER	RELATIONSHIP TO PATIENT

PROTECTED HEALTH INFORMATION DISCLOSURE OVER THE PHONE

The provider(s) and/or staff have my permission to:

☐ Leave a detailed message with the person(s) listed above

☐ Leave a detailed message on my primary voicemail: (_____) - ____ - _____

☐ Leave a detailed message on my business voicemail: (_____) - _____ - _____

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT IF THEY ARE NOT A COVERED ENTITY UNDER THE FEDERAL PRIVACY RULE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING ADDISON PAIN AND REGENERATIVE MEDICINE IN WRITING, TO BE EFFECTIVE ON THE DATE NOTIFICATION IS RECEIVED. I AGREE THAT MY AUTHORIZATION IS VOLUNTARY.