Pain Institute
of Southern Arizona

Appointment Scheduling: (520) 999-9000
General Inquires: (520) 318-6035
Fax: (520) 795-9953
www.pisapain.com

Authorization for Release of Information to Family Members

Directions: If filling out the form on your computer, save the file and then attach the form to an email and send to patientforms@pisapain.com. If filling out the form on your phone, forward as an email (using the icon) and email to: patientforms@pisapain.com. You can also print the forms to write the answers, then scan or take a photo of the forms and email to patientforms@pisapain.com.

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Pain Institute of Southern Arizona to release my medical and/ or billing information to the following individual(s):

1. Name: _____ Relation to Patient: _____

2. Name: _____ Relation to Patient: _____

3. Name: _____ Relation to Patient: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclose by the above recipient.

You have the right to revoke this consent in writing.

Patient Name: _____ Date: _____