UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

I hereby authorize (name of provider/address):

____

____

I hereby authorize any and all Pharmacies to release my prescription history.

To disclose the following information from the health records of:

Name:____
Last First MI Previous Name

Birthdate: ________________Social Security #:______________

Telephone: (H)_______________(W)_________________________

Address: ____
Street City State Zip

This information is to be disclosed to:

Universal Pain Management Medical Corporation

819 Auto Center Drive Palmdale, Ca. 93551

Phone (661-267-6876 Fax (661) 538-9483

Covering the periods of healthcare (Date(s) of service):

From (date)__________________________ to (date)________ **Present** __________

For the purpose of:____
(Not required if the disclosure is requested by the patient)

The following information may be released:
All information may be released

____

TURN OVER ➔

UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that this will include information relating to **(check and initial, if applicable):**

- ☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
- ☐ Behavioral health service/psychiatric care.
- ☐ Treatment for alcohol and/or drug abuse.

If compensation will be received: I understand that ____________________ will receive compensation for its use/disclosure of the information release pursuant to this authorization.
Patient's initials: ____________

Affirmation of Release:

I give __________ **See Front** ____________ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency (ies) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

______________________________________ ______________________
Signature of the Patient/Guardian/Legal Representative Date Signed

______________________________________ ______________________
Signature of Witness/Relationship to Patient Date Signed

Expiration date: ______________________________
One year from date signed

TURN OVER —►