ADVANCED INTERVENTIONAL
PAIN CONSULTANTS

AUTHORIZATION FOR SHARING PHI

Patient Name: _____DOB: _____ DATE: _____

Please list other people (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other doctors/specialists) with whom we may share your **Protected Health Information**.

(Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

What other ways may we contact you? Please list any that are acceptable to you:

		Is it ok to leave a message?	
	#	Yes	No
HOME			
CELL			
WORK			
OTHER			

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

☐ Parent or guardian of emancipated minor

☐ Court appointed guardian

☐ Executor or administrator of decedent's estate

☐ Power of Attorney