# Javery Pain Institute, PC

## Authorization For Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____

**Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:**

o Medical Care / Treatment: **Yes** ___ **No** ___ **Level of Information** _____
o Billing Information **Yes** ____ **No** ____
o Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes** ___ **No** ___
o Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.) _____
_____

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Javery Pain Institute, PC, 710 Kenmoor Ave SE, Suite 200, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date _____
Parent / Guardian Signature

I request that all communications to me (by telephone, mail, etc.) by Javery Pain Institute, PC. and/or its staff be handled in the following manner:

* For **written** communications: Address to: _____

* For **oral** communications: Call: _____ May we leave a message? YES ☐ NO ☐
(telephone number)

If the above address is not a street address or is not your home address, please provide us with a (home) street address for purposes of ensuring payment:

_____
(street number and address) City State Zip

_____ _____/_____/_____
Patient Signature Date

*Needed for alternative Written or Oral communication listed in above box only.*
***For Practice Use Only***: Practice: Accepts ☐ Denies ☐

Privacy Officer's Signature _____ Date: _____