

Javery Pain Institute, PC

Name: _____ Date of Birth: _____ Patient ID: _____
Last First MI

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:

- Medical Care / Treatment: Yes ___ No ___ Level of Information _____
- Billing Information Yes ___ No ___
- Pick up PHI: (such as prescriptions, billing statements, labs etc.) Yes ___ No ___
- 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.

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

Parent/Guardian 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: _____