



85 First Avenue, Waltham, MA 02451
(781) 895-7960 Fax: (781) 290-0720 www.bostonsleepcare.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Full Name: _____ Date of Birth: _____
SSN: _____ SEX: _____ Marital Status: _____
Address: _____
Phone #: _____ Work Phone #: _____
Cellphone #: _____ Email Address #: _____

I hereby authorize Boston PainCare Center, Boston Surgery Center, and Boston Sleepcare Center to use or disclose my protected health information as indicated below:

Name: _____ Daytime Phone: _____
Fax: _____
Address: _____

Information to be released:

From & To Dates: _____ All _____
 Physical Performance Measurement Test (Don Counihan) X-Ray / MRI / CT Injection Notes Sleep Notes
 Med. Management Physical Therapy Notes Dr. Dhar

Purpose of Disclosure:

Changing Physicians Second Opinion Continuing Care Legal At my (patient) request
 Insurance Workman's Compensation School Other: _____

- 1. I understand that I may revoke this authorization at any time by notifying Rachel Porter, Privacy Officer, in writing. Submitting a written request will terminate this authorization, unless it has already been acted upon.
- 2. I understand that my private health information will no longer be protected by federal privacy regulations. However, federal law prohibits disclosing specifically protected information, such as substance abuse treatment, HIV/AIDs related, and psychiatric / mental health information.
- 3. I understand that I will get a copy of this form after I sign it.

By signing below, I have acknowledged that I have read and understand this Authorization.

Patient/Legal Guardian Signature: Date: _____

FOR OFFICE USE ONLY:

Date Request Filled _____ by _____ Chart # _____ Fee \$ _____