San Diego Pain Institute

Douglas Dobecki, M.D.
5395 Ruffin Road, Suite 202
San Diego, CA, 92123
T (858) 576-1011
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RETRIEVE MEDICAL RECORDS

Patient's Name: _____ **Date of Birth:** ___/___/_____

I voluntarily authorize and direct the healthcare provider named below to disclose my health information during the term of this authorization to **San Diego Pain Institute**.

Provider Releasing Records:

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Provider Receiving Records:

San Diego Pain Institute

5395 Ruffin Road, Suite 202

San Diego, CA 92123

Phone #: 858-576-1011

Fax #: 858-576-1025/1026

Information to be disclosed: This authorization permits the above named health provider to disclose the following medical records. **(Please check one box)**

□ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation: x-rays, HIV/AIDS status, genetic testing, psychotherapy or other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other healthcare providers that the above-named healthcare provider may hold.

□ All of my health information described above except the following: _____

_____

□ Only the following records or types of health information (please specify dates of treatment, types of treatment or other designation): _____

_____

Term: This authorization will remain in effect for one (1) year from the date this authorization is signed.

Refusal to sign/Right to revoke: I understand that I may refuse to sign or may revoke at any time this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health provider. I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my healthcare provider, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this authorization before it received my written notice of revocation.

Questions: I may contact my provider's office for answers to my questions about the privacy of my health information. I understand that I have the right to receive a copy of this authorization from my health care provider. A photocopy, fax, or electronic copy of this authorization shall be considered as effective and valid as the original.

Printed Name of Patient and/or Representative: _____

Signature of Patient or Representative: _____ **Date:** ___/___/_____

Signature of Witness: _____ **Date:** ___/___/_____