Integrated Pain Specialists of Southern California, Inc.

Kevin S. Smith, M.D.
7525 Linda Vista Road, Suite C, San Diego, CA 92111
Phone: (619) 398-2988 Fax: (619) 398-2987

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION:
I hereby authorize the release of information between the following two parties, regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

From: _____ (name of person, healthcare provider, or facility)

Phone: _____ Fax: _____

To: **INTEGRATED PAIN SPECIALISTS OF SOUTHERN CALIFORNIA, INC. DBA. KEVIN S. SMITH, M.D.**
Address: **7525 LINDA VISTA ROAD, SUITE C** City, State, Zip: **SAN DIEGO, CA 92111-5344**
Phone: **(619) 398-2988** Fax: **(619) 398-2987** Please send records by: ❑ Fax ❑ Mail

The medical information/records will be used for the following purpose:
PAIN MANAGEMENT CONTINUATION OF CARE

This authorization is:

- ❑ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV, Diagnosis/Treatment)
- ❑ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)
Psychiatric/Mental Health _____(initial)
Tests for Antibodies to HIV _____(initial)
HIV Diagnosis/Treatment _____(initial)
Genetic Information _____(initial)

DURATION:
This authorization shall be effective immediately and remain in effect until: _____(date)
***** If no duration date is specified, the form will remain valid for one (1) year from the signature date below. *****

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Signature of Patient (*or legal/personal representative)*
Relationship (*if other than patient)*
Patient's Name (*please print)*
Today's Date
Patient's Social Security Number
Patient's Date of Birth
Witness Name
Witness Signature