AUTHORIZATION FOR
USE, REQUEST, OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

_____

(Print **First Name, Middle Initial, Last Name**)

_____

(**Phone Number**) (**Date of Birth**)

_____

(**Patient Street Address, City, State, Zip Code**)

I hereby authorize Edward Poon, MD to use, request, re-disclose or disclose any or all of my Protected Health Information to or from any entity involved in the delivery or payment of my medical care.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to:

PAIN CONSULTANTS & INTERVENTION- EDWARD POON, MD
3860 Masthead Street NE
Albuquerque, N.M. 87109
Phone: 505.828.1010

I understand that I have the right to inspect or copy Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

_____ _____
Patient Signature Date

OR

_____ _____
Signature of Authorized Representative Description of Person Representative's Authority