JOSE G. VELIZ MD, INC.
Diplomate of the American Board of Interventional Pain Management
Diplomate of the American Board of Anesthesiology
Diplomate of the American Board of Pain Medicine
Fellow of Interventional Pain Practice

PALOMAR SPINE &PAIN

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:_____(Physician/Healthcare Facility)
Phone#:_____ Fax#:_____

To release information on _____(Patient's Name) _____(Patient's DOB) 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.

To: **Jose G. Veliz, M.D., M.S.A., Inc.**
255 North Elm Street, Suite 101
Escondido, CA 92025
(760)489-1876 / Fax: (760)489-1748

The medical information/records will be used for the following purpose:

_____

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

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 patient* Relationship if other than

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness name Witness signature

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