Helix Pain Solutions
851 Meadows Road. Suite 212. Boca Raton. Florida – 33486
Office: 561 392-1979 Fax: 561 392-9707

Authorization for Use of Protected Health Information

Patient Name	
Date of Birth	Phone Number

1. I authorize Helix Pain Solutions to disclose and/or receive my health information if applicable, including but not limited to:

All of my health information, Any and all medical records, Practitioner summaries, History and physical exam, Office charts, Office notes, Emergency room report, Laboratory testing results, Diagnostic testing results, Radiology reports, Surgical notes, Discharge summaries, Consultations, Prescriptions, HIV testing results, Treatment for alcohol and/or drug abuse, Mental health treatment, Genetic testing, and/or any pertinent information related to my injury/illness and/or settlement.

2. I understand that if the person(s) or entity (ies) that received the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Helix Pain Solutions, its employees, and my physicians from all liability arising from this disclosure of my health information.

3. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will not expire from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.

4. ☐ I DO NOT authorize the release of my medical information other than to myself.
5. ☐ I DO authorize the following person(s) to receive or discuss my medical conditions:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please send all requested information to:

Helix Pain Solutions. 851 Meadows Road. Suite # 212. Boca Raton, Florida – 33486
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I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclose of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize Helix Pain Solutions to use or disclose my health information in the manner described above.

Patient Signature	Date