NY SPINE CARE
INTERVENTIONAL PAIN MANAGEMENT
188-16 Northern Blvd
Flushing, NY 11358
Office: (718) 762-7000
Fax: (718) 762-7002

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name		Date of Birth	
Patient Street Address	City	State	Zip
Home Phone	Cell Phone	Preferred Contact (Circle) **Home** / **Cell**	

I, above named patient, authorize NY Spine Care Interventional Pain Management d/b/a NY Premier Medical Practice, P.C. to discuss my medical and/or billing information to the following individual(s):

1. Name _____

   Address _____

   Phone Number _____

   Relationship _____

2. Name _____

   Address _____

   Phone Number _____

   Relationship _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient(s).

I understand I have the right to revoke this consent in writing.

Signature _____ Date _____