Authorization Form for Release of Protected Health Information (PHI) to Botox Reimbursement Solutions

PATIENT NAME	DOB	TEL
ADDRESS		

I hereby authorize Diamond Headache Clinic Ltd to release my PHI to Botox Reimbursement Solutions.	
Diamond Headache Clinic Ltd	1460 N Halsted St Ste 501 Chicago, IL 60642
Tel. 773-388-6390	Fax. 312-867-7101
Release to:	
Botox Reimbursement Solutions	PO Box 1370 San Bruno CA 94066
800-44-BOTOX	877-530-6680

I hereby authorize Diamond Headache Clinic to release all relevant medical records regarding the above patient excluding mental health treatment, alcoholism treatment drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.
The purpose of the authorization is the disclosure pertinent medical information for the prior authorization of BOTOX medication and procedure.
I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization ma be subject to re-disclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid for **one (1) year**, unless otherwise specified below. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. The written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health.
Expiration Date (if not one (1) year):

SIGNATURE OF PATIENT/ REPRESENTATIVE	DATE
PRINT NAME OF SIGNER	RELATIONSHIP