Advanced Pain Management Center

****HIPAA CONSENT FORM****

I understand that as part of my healthcare, Advanced Pain Management Center originates and maintains electronic health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided the NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Advanced Pain Management Center reserves the right to change their and practices and prior to implementation will mail a copy any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and understand that I may revoke this consent in writing, except to the extent that Advanced Pain Management Center has already taken action in reliance thereon.

I also authorize the person(s) listed below to receive information regarding my appointments or treatments while a patient at the Advanced Pain Management Center.

NAME	RELATIONSHIP
_____	_____
_____	_____

I request the following restrictions to the use or disclosure of my health information:

Release of Records

I authorize Advanced Pain Management Center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices

I acknowledge that I have received and read the Notice of Privacy Practices of Advanced Pain Management Center.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature: _____

Please print your name: _____

Date: _____