HIPAA FORM

This is my consent for Pain and Rehabilitation Consultants LLC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view Pain and Rehabilitation Consultants Notice of Privacy Practices.

This is my consent for Pain and Rehabilitation Consultants LLC to:

- ________Call my house and leave a message on voicemail or in person to remind me of appointments or obtain insurance information. We may have an automated service that will remind you of your appointment date and time.
- ________Call and leave reports of my clinical care; lab results.
- ________Mail items that assist in carrying out my treatment, payment, or health questions such as appointment reminder cards and patient statements to:
    A. _________Home
    B. _________ Other Location:___________________________________
- ________My entire medical record may be released if requested with a signed release form.

This is my consent for information regarding my health and treatment to be discussed with the following people in the event of an emergency please print their name and telephone number:

- ____________________________________ ______________________________
  Name Phone Number
- ____________________________________ ______________________________
  Name Phone Number

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.____________________________(Please initial).

I understand that: I may refuse to sign this authorization and that is strictly voluntary. My treatment, payment, enrollment or eligibility of benefits may not be conditioned on signing this authorization. If the requestor or receiver is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions take prior to receiving the revocation.

By signing this form, I am consenting to Pain and Rehabilitation Consultants, LLC use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that Pain and Rehabilitation Consultants, LLC reserves the right to refuse to treat me if I do not sign this consent form. This authorization will expire in one year from the date as hearby stated.

_________________________________ ______________________________ ___________________

Patient Name (Printed) Patient Signature Date