Expert Pain Physicians

Pain & Spine Wellness Center

***** HIPAA CONSENT FORM *****

HIPAA is an acronym for the Health Insurance Portability and Accountability Act ("HIPAA") enacted into law in 1996. Under HIPAA, if you are 18 years or older, you have the right to strict confidentiality regarding your visits to and treatment from Expert Pain Physicians. To release any information, including the date or reason for your visit, Expert Pain Physicians must have your signed consent and specific direction about what information may be released. Without your written consent, HIPAA prohibits Expert Pain Physicians from releasing or discussing information relating to your care and treatment with any third party, including, but not limited to, parents, guardians, spouse, faculty, staff, or coach.

By signing this consent, you are granting authorization to Expert Pain Physicians to disclose information pertaining to your visits and care and treatment, or that of your dependents, to third parties that would otherwise be unable to receive such information from Expert Pain Physicians. The private health information that Expert Pain Physicians may disclose by your signing this consent includes history and physical information, social history, treatment and treatment plans, assessments, progress notes, consultations, reports of imaging studies, reports of procedures performed and medicine administration records. This information will be disclosed to other physicians, hospitals, surgery centers, your health insurance carrier and other payors of medical benefits. The health information disclosed pursuant to this consent may be disclosed by the recipient and may, as a result of this disclosure, no longer be protected to the same extent this information was protected by law while in the custody of Expert Pain Physicians.

You may revoke this consent at any time by giving written notice of revocation to Expert Pain Physicians either by U.S. mail or personal delivery. Your revocation will be effective upon receipt by Expert Pain Physicians. You acknowledge that you will not be able to revoke this consent where Expert Pain Physicians has relied on this consent to disclose your health information.

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Patient Name/Guardian (if under 18) (print) **Date**

X____

Signature