

CONSENT FOR THE USE AND /OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Dayton Pain Center, LLC, to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Our notice of Privacy practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment and health care operations. We are not required to grant your request, but if we do, the restrictions will be binding on us.

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. 164.524).

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the office address. You may deliver your revocation by any means you choose (personally or mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name of the Patient: \_\_\_\_\_

If you are signing as the patient’s representative:

Print your name: \_\_\_\_\_

Describe your authority: \_\_\_\_\_

REVOCATION

I HEREBY REVOKE THE CONSENT GIVEN ABOVE.

Sign: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print name of the patient: \_\_\_\_\_

If you are signing as the patient’s representative:

Print your name: \_\_\_\_\_

Describe your authority: \_\_\_\_\_