LINCOLN.B. PAIN CLINIC, LTD.

COMPASSIONATE PAIN MANAGEMENT.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

Patient Name:_____
Patient's SSN: _____._____._____. Patient's Date of Birth: _____._____._____

A. Person(s) or Organization(s) authorized to provide information.
Lincoln. B. Pain Clinic, Ltd.

B. Person(s) or Organization(s) authorized to receive information:

C. Specific description of the information that may be used or disclosed(Including date(s))
ALL MEDICAL RECORDS.

D. Specific description of how the information will be used:
WHATEVER IT IS NEEDED FOR.

1) I understand that this authorization will expire on (date)._____._____._____
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying. (insert name of practice)_____in writing.
3) I understand that I **can refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits(if applicable)
4) I my **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information in not a health care provider covered by federal privacy regulation, the information described above may be re disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative. Date.

_____ _____
Printed Name of Patient's Representative. Relationship to Patient.

Note:
You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/ 4/ 03" or, if your entire medical record is included, "all health information.")
You have a right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information.(e.g, the name of your health care provider(s).)
You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD/Research).

HIPAA Authorization for Release of Information.

This form does not constitute legal advice and cover only federal, not state laws.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRVACY PRACTICES.

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, it you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here.

Signature.
Date._____/_____/_____.

FOR OFFICE USE ONLY.

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.
Due to an emergency situation it was not possible to obtain an acknowledgment.
We weren't able to communicate with the patient.
Other. (Please provide specific details.)

_____
_____
_____
_____

_____ _____
Employee Signature Date.

HIPAA Authorization for Release of Information.

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