ADVANCED PAIN MODALITIES

3195 W. RAY RD. SUITE 1, CHANDLER, AZ 85226

PATIENT CONSENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient_____ Date_____

I understand that my (the patient's) health information is private and confidential and that Advanced Pain Modalities (from here on will be known as APM) will endeavor to protect and preserve the confidentiality of that information.

I understand that APM may use and disclose my (the patient's) health information to provide treatment to me (the patient), to handle billing and third-party payment and to take care of other healthcare operations.

I understand that APM has a detailed document called the *Notice of Privacy Practices*. It contains more detailed information about how this office may use and disclose patient health information. I understand that I have a right to read the Notice before I sign this consent.

I understand that APM may update this Notice at any time. If I ask, this office will provide me with the most current Notice.

I understand that under the terms of this consent, I may ask APM to restrict how my (the patient's) health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that this office does not have to agree to my (the patient's) request. If this office does not agree to my (the patient's) request, I understand that this office will follow those limits previously agreed to

I understand this consent shall be in force and effect as long as I am a patient of APM unless I chose to revoke it. I understand that I may revoke this consent in writing any time by writing, signing, and dating a letter to APM. If I write a letter, it must say that I want to revoke my (the patient's) consent to authorize the use and disclosure of my (the patient's) health information for treatment, payment, and healthcare operations.

I understand that if I revoke or refuse to sign this consent, APM does not have to provide any further health care services to me (the patient).

The signature below indicates that I (the patient) have been given the chance to review a current copy of APM's *Notice of Privacy Practices*. The signature means that I (the patient) agree and consent to allow this office to use and disclose my (the patient's) protected health information to carry out treatment, payment, and health care operations.

_____ _____

Signature of Patient, or Personal Representative (Date)

_____

Relationship to Patient if signed by anyone other than the patient

_____ _____

Refused (Date)