Integrated Pain Management
244 E. Roosevelt Rd. Lombard, IL 60148
Phone: (630) 629-6298 Fax: (630) 599-7149

Authorization for the Use and/or Disclosure of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosure pursuant to this authorization.

   All medical information to include x-rays and diagnostic studies

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information.

   Integrated Pain Management

3. I authorize the following persons (or class of persons) to receive my protected health information:

   Integrated Pain Management

4. 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.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to: Integrated Pain Management. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization is effective through _____ unless revoked or terminated earlier by the patient or the patient's representative.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Integrated Pain Management nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request for the following purposes:

   Accurate necessary treatment of medical conditions to ensure highest standard of care

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclose, (in accordance with the requirements of the federal privacy protection regulations).

I certify that I have received a copy of the authorization.

Signature_____ **Date** _____

Print Name_____

Name of Patient Representative_____

Relationship to Patient_____