HIPAA RELEASE & NOTICE OF DISCLOSURE

Pain & Neurology Specialists of Columbia, P.A. is authorized to release protected health information about the above named patient to the entities named below.

May we leave appointment reminders, prescription information, and messages to call our office back on your answering machine or voicemail?

□Yes □No

May we share information with your Attorney?

□Yes Attorney's Name: _____ □No □N/A

May we share information with your spouse, caretaker, or child(ren)?

□Yes □ No

If yes, please list their name(s): _____

May we share information with your employer? □Yes □No

If yes, please list the contact person at your employer: _____

Rights of the patient: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by sending a written notification to Pain & Neurology Specialists of Columbia, P.A. I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoke by the patient.

Acknowledgement of Receipt of Notice of Privacy Practice: I hereby acknowledge that I received a copy of the Pain & Neurology Specialists of Columbia, P.A. Notice of Privacy Practices. Copies follow this form.

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Patient or Patient Representative Signature

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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Patient or Patient Representative Signature