Community Pain Consultants, Ltd

Relieving pain, improving life!

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practice Form

Patient Name: _____ DOB: _____

Consent for Release and Use of Confidential Information

I hereby give my consent to Community Pain Consultants, Ltd., to use or disclose, for the purpose of carrying out treatment, payment, or health care operations all information contained in my private health care record.

Notice of Privacy Practices

I acknowledge the receipt of the physicians' Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change the privacy practices that are described in the notice. I also understand that a copy of a revised notice will be provided to me or made available by mail upon request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving a written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Patients Signature_____ Date_____