Centers for Pain Management, LLC

Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, _____, hereby authorize Centers for Pain Management, LLC to (check those that apply):

☐ Use the following protected health information, and/or
☐ Disclose the following protected health information to _____:

_____
_____.

This protected health information is being used or disclosed for the following purposes:

☐ Legal Issue ☐ Continuing Care ☐ Personal Use ☐ Insurance Claim ☐ Other: _____

This authorization shall be in force and effect until one year from the date signed, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Centers for Pain Management, LLC at 1493 Kennedy Road, Suite B Tifton, Georgia 31794. I understand that a revocation is not effective to the extent that Centers for Pain Management, LLC has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Centers for Pain Management, LLS will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)
- Refuse to sign this authorization

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Witness