

Brevard Pain Management, Inc.

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PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand Brevard Pain Management, Inc. is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Brevard Pain Management, Inc., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (*check all that apply*):

- Medical Data/Information as related to:
- Specific condition(s): _____
 - Specific Professional service(s) _____
 - Specific Medication(s) _____
 - Other: _____

- (*check if applicable*) This authorization is to be used for our own use, and Brevard Pain Management, Inc. will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Brevard Pain Management, Inc. must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number
- The effective date of this authorization, and the recipients of the protected health information according to this authorization
- The patient's desire to revoke this authorization, and
- The date of revocation, and the patient's signature.

Brevard Pain Management, Inc. will accept written revocations of this authorization via

- Facsimile at 321-264-0472 (Titusville office) or 321-757-0474 (Suntree office)

ALL revocations must be sent to Brevard Pain Management, Inc. to the attention of the Privacy Officer, Alicia or Pam, and are not effective until received by the Privacy Officer.

Patient's signature

Date

Patient's name:

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____