Alliance Pain Management
Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1196 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.)
- Obtaining payment from third party payers (my insurance company).
- The day-to-day healthcare operations of our practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these restrictions. However, if you do agree you are then bound to comply with this restriction. I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail and/or telephone, including leaving messages on your answering machine/voice mail.**

I authorize contact from Alliance Pain Management to contact me by:

☐ phone numbers listed below

☐ leave a message on my voicemail or to verify my appointments with the person or people listed below.

☐ by mail via USPS

Alliance Pain Management is authorized to discuss my medical information with the following individuals in accordance with HIPAA guidelines:

Name / Phone Number	Relationship	Phone Number
1.		
2.		

This request supersedes any prior request for communication of information I may have made.

Print Patient Name/ Responsible Party: _____ Date: _____

Signature of Patient/Responsible Party: _____ Date: _____