AUTHORIZATION TO OBTAIN / RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by **Florida Pain Management Center** in order to carry out treatment, payment, or healthcare operations. **I also hereby authorize FPMC to request all medical "Protected Health Information" in order to carry out medical treatment**. I have been informed of the "Notice of Privacy Practices" for a more complete description of the potential release and use of such information. I have also been informed I have the right to review such Notice prior to signing this Consent Form.

FPMC reserves the right to change the terms of its Notice of Privacy Practices at any time. If changes to the terms of its Notice of Privacy Practices are made, I may obtain a copy of the revised Notice. I retain the right to request FPMC to further restrict how my protected health information is released or used to carry out treatment, payment or health care operations. FPMC is not required to agree to such requested restrictions; however, if they do agree to my requested restrictions(s), such restrictions are then binding on FPMC. **I acknowledge and agree that the FPMC may disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:**

Name of individuals authorized to received my health protected information:

I agree that Florida Pain Management Center may also disclose the following types of information contained in my medical record (**please initial** the appropriate categories listed below):

- ☐ HIV/AIDS Information
- ☐ Mental Health Information
- ☐ Substance Abuse Information
- ☐ Sexually Transmitted Disease Information
- ☐ If Patient is under the age of eighteen (18), Pregnancy Information

Florida Pain Management Center may refuse to treat if I (or any authorized representative) do not sign this Consent Form.
If I (or authorized representative) sign this Consent and then revoke it, FPMC has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent, (if requested) and I am the patient (or the authorized party to act on the behalf of the patient to sign this document) verifying consent to the above terms.

___________________________________ Signature of Patient or authorized representative

___________________________________ Please Print Name

Date: ____________________

DOB: _______/______/______ SS#______________________________

*Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the patient:

Please complete, sign and return to The Florida Pain Management Center