AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I authorize the use or disclosure of the above-named individual's health information from/to my referring physician and other specialists involved in my care. The following additional individual or organization is authorized to make/receive the disclosure i.e., Lawyer, Spouse, etc.:

_____

The type and amount of information to be used or disclosed is the entire medical chart including medical records, office notes, hospital records, pharmaceutical records, laboratory records, X-ray and MRI films, CAT scans, any other radiological films, and medical bills.

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, pregnancy, and/or family planning.

This information may be disclosed to and used by the following individual or organization for medical evaluation and treatment:

New York Pain Management, LLC
9 Old Plank Road, Suite 100
Clifton Park, NY 12065

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains the health insurance.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for unauthorized re- disclosure, and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as the original.

WRITE YES OR NO IN SPACE PROVIDED.

_____ INSURANCE AUTHORIZATION - I hereby authorize New York Pain Management, LLC, to furnish information to my insurance carriers concerning my illness and treatment.

_____ ASSIGNMENT OF BENEFITS - I hereby assign to New York Pain Management, LLC, all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

_____ OUT OF NETWORK- I understand it is my responsibility to know my insurance plan benefits and whether a provider is in my network. I agree that I am fully responsible for any costs incurred.

_____ TREATMENT AUTHORIZATION - I hereby authorize New York Pain Management, LLC, to render health care to me during my visit.

_____ APPOINTMENT AUTHORIZATION – I hereby authorize New York Pain Management, LLC, to communicate with me regarding my appointments using my answering machine, other Voice Mail, and authorized persons. AUTHORIZED PERSONS:

_____

PATIENT SIGNATURE DATE

_____

WITNESS SIGNATURE DATE