Consent for Release of Protected Health Information

Scott Integrated Pain Management, LLC

1601 Walnut Street, STE 522 | 215-825-5979 | tomscott@scottpain.com

Name of Patient ___________________________________ Date of Birth ________________________________

Care coordination is an essential part of the management of complex chronic conditions such as pain. As such, the above-named patient, gives Scott Integrated Pain Management LLC permission to disclose protected health information (including, but not limited to medical diagnoses/impressions, test results, clinic notes, and management plans) to providers with whom this patient maintains an ongoing therapeutic relationship. Any exceptions shall be noted below. Unless you object, we may disclose to a member or your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. Please discuss the nature, as specifically as possible, you wish to be withheld.

Do NOT disclose protected health information to the following healthcare providers and healthcare professionals.

Name of person/entity ____

Name of person/entity ____

Name of person/entity ____

I do NOT give permission to discuss protected health information with the following family/friends

Name of person/relationship Type of Information: [] financial/billing

____________________________ [] medical diagnoses

[] treatment plan

[] test results

Name of person/relationship Type of Information: [] financial/billing

____________________________ [] medical diagnoses

[] treatment plan

[] test results

___________Initials

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Name of person/relationship

____

Type of Information:

[] financial/billing

[] medical diagnoses

[] treatment plan

[] test results

I understand that I have the right to revoke or modify this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

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Patient Name Printed

____

Patient Signature and Date

____________Initials