Authorization for the Use and Disclosure of Protected Health Information

Southern Illinois Pain Management, SC

3905 West Ernestine Drive - Marion, IL 62959
130 East Clark Street – Harrisburg, IL 62946
300 South Mt. Auburn Ste 200 – Cape Girardeau, MO 63703

As required by the Health Insurance Portability and Accountability Act of 1996 1a may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

<u>AUTHORIZATION SECTION</u>

I, ____________________ (print name) hereby authorize the use and disclosure of the following health information that pertains to me

Medical Records

for the following purpose<s>:

Treatment, Payment, Regular Health Care Operations

I authorize the following persons to make these disclosures of my health information:

Southern Illinois Pain Management, S.C.

I authorize the following persons to receive these disclosures of my health information:

Myself, Referring Physician, Primary Care Physician, Insurance Company, __________
Example: daughter, son, spouse, care giver

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire one year from the last date of service seen by this practice.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way on whether I sign this authorization or not

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

________________________________ ________________________________
Signature Date

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REVOCATION SECTION

I hereby revoke this authorization.

__________________________________ __________________________________

Signature Date

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