THE BIRMINGHAM PAIN CENTER

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Authorization to Disclose Protected Health Information

In order to provide for your healthcare, **The Birmingham Pain Center** collects information about your medical history, physical examinations and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, healthcare providers must obtain a valid authorization in order to release any such information to a third party for purposes not related to your treatment, receiving payment, or healthcare operations. This authorization gives **The Birmingham Pain Center** permission to disclose the elements of your protected health information listed below for the specified purposes to the stated recipient.

I understand that I am not required to sign this authorization, and that my treatment is not conditioned on signing, except as described below. A copy of this authorization will be provided to me if **The Birmingham Pain Center** initiated the request for this authorization.

Exceptions: **The Birmingham Pain Center** may condition treatment on signing an authorization for disclosure to a third party if the sole reason for treatment is for disclosure to that party (e.g., a physical being paid for by an insurance company in order to determine eligibility for a policy). Also, provision of treatment that is part of a research study may be conditioned on an authorization to disclose protected health information as required for the conduct of the clinical trial.

Therefore, I, _____ *(patient or personal representative)* consent that _____ may disclose the following health information of:

❑ myself or ❑ (specify:) _____.
(*If signing as a personal representative, documentation of your legal right to do so must be provided and attached.*)

Specific health information to be disclosed, including date(s).
Include:

- ❑ Progress Notes
- ❑ Labs
- ❑ X-rays
- ❑ Complete Medical Record
- ❑ Other: _____
- ❑ Other: _____

- ❑ from: ____/____/20____
  to: ____/____/20____
- ❑ for Dr. _____
- ❑ Other: _____

Purpose (Mandatory):

- ❑ Legal
- ❑ Insurance
- ❑ Patient Request
- ❑ Other (be specific): _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
I hereby specifically authorize the release of data and information relating to: (check any that apply)
❑ HIV/AIDS related testing ❑ Chemical Dependency (Drug/Alcohol) ❑ Other: _____

If this authorization is initiated by The Birmingham Pain Center for the purpose of marketing, The Birmingham Pain Center ❑ will ❑ will not receive any direct or indirect financial or other compensation as a result of the requested disclosure. If compensation is to be received, this consists of the following:

The health information requested is to be disclosed to:

Recipient _____

Address _____ Phone: _____

_____ Fax: _____

City _____ State_____ Zip Code _____

This authorization will remain valid for 180 days from the date it is signed or until_____/_____/20____(whichever is shorter)

or until the following event related to this authorization takes place:_____,
after which time it will become invalid.

I understand that protected health information released to a third party that is not subject to HIPAA regulations will no longer be protected, and may be subject to re-disclosure. Only providers of healthcare (organizations that provide medical or health services or medical supplies), health plans (organizations that pay for medical care), and healthcare clearinghouses (organizations that convert health data into the required format for electronic transmittal) are covered by HIPAA I understand that I may revoke this authorization in writing at any time, but that this revocation will not affect any prior authorized disclosures that have been taken by **The Birmingham Pain Center** .

_____	___/___/20___	_____	_____
Signature of Patient or Personal Representative	Date	Printed Name	Relationship to Patient (if not self)

You may revoke or terminate this authorization by submitting a written revocation to The Birmingham Pain Center. Contact Privacy Officer.