Centurion Pain Management

HIPPA / AUTHORIZATION TO RELEASE INFORMATION

Your protected health information (PHI) will only be used with your consent to provide you treatment, to obtain payment from your health insurer, for case management and care coordination and health care operations. For any disclosure of PHI outside of this consent we will require written authorization from you. We may use or disclose your PHI if law or regulations requires the use or disclosure, such as but not limited to, legal proceedings, workman's compensation laws, and a threat to the health and safety of others. Your PHI will not be shared with a family member, close friend or any other person without written consent by you. The only exception is for minor children (age 17 and under); the parent or legal guardian will have the right to the information.

You have the right to inspect and obtain a copy of your PHI which will be done usually within 30 days of your request. We may charge a reasonable, cost-based fee. You may request an amendment of your PHI for as long as the PHI is maintained in the record. You have the right to request in writing, that we not use any part of your PHI for treatment, payment or health care operations. However, if we believe that the restriction is not in the best interest of either party or we cannot reasonably accommodate the request; we are not required to agree to your request. You have the right to receive confidential communication by alternative means and at alternative locations. For example, you can request to be contact at the home or office phone or you can request your bills be sent to another address if reasonable.

You can request to correct your medical information if you feel is incorrect or incomplete, however we are not required to agree to your request. We will inform you in writing within 60 days.

We cannot control or be held responsible for any third party misuse of your PHI. If you feel that your rights have been violated, please contact the office manager. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Please list all other persons you have choose to act for you, therefore we may speak to, on your behalf and their relationship to you (for example parents, spouse, legal guardian, or somebody you have given medical powerof attorney): _____

It is our responsibility to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing below, you state that you have read and understand the above information and consent to the use of your PHI as outlined. A photocopy of this shall be considered as effective and valid as the original.

Print patient name:

_____

Signature: _____ **Date:** _____

If minor, please state relationship to patient: _____