



## **CONSENT TO USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

### **Use and Disclosure of Your Protected Health Information**

Your protected health information will be used by Advanced Pain Management (APM) or disclosed to others for the purposes of treatment, obtaining payment or supporting the day to day healthcare operations of the practice.

### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

### **Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your information.

Advanced Pain Management (APM) may or may not agree to restrict the use or disclosure of your protected health information. If Advanced Pain Management (APM) agrees to your request, the restriction will be binding on the practice. Use or disclosure of your protected health information in violation of an agreed upon restriction will be a violation of federal privacy standards.

### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### **Reservation of Right to Change Privacy Practices**

Advanced Pain Management (APM) reserves the right to modify the privacy practices outlined in the notice.

### **Signature**

I have reviewed this consent form and give my permission to Advanced Pain Management (APM) to use and disclose my health information in accordance with it.

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Name of Patient (Please print)

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Signature of Patient

Date:

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Signature of Patient Representative/Relationship of Patient

Date: