Release of Health Care Information by Pain Solutions to Below Authorized Person

Name of Individual to whom Health Care information may be released

1. _____(herein "Authorized Person(s)")
2. This authorization specifically applies to all health care records currently and in the future present at Pain Solutions and allows Pain Solutions to disclose protected health information to Authorized Person.
3. The purpose of the use and disclosure by Pain Solutions to Authorized Persons shall include assistance by my Authorized Person(s) in monitoring and sharing my health care status with family and friends for my benefit.
4. I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, as well as the exceptions to my right to revoke will be performed in accordance with applicable federal law and any applicable policy of my health care provider.
5. I understand that, I may refuse to sign this Authorization. I also understand that my healthcare provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.
6. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure.
7. The authority given to said Authorized Person(s) shall supercede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

I have read and understand the information in this authorization form.

Signature: _____ Date: _____

Print Name: _____

Witness: _____ Witness: _____