

HIPAA

Health Information Portability and Accountability Act

I have received notification and a copy of the HIPAA (Health Information Privacy and Accountability Act) as this pertains to my treatment with Pain Management Associates of Lubbock.

- 1) I authorize my doctor and his clinic staff to release my private medical information to:
(Example: family members, attorney, friends, social security administration)

Please provide us with the NAMES of these people or class of people:

- _____
- _____
- _____

- 2) I authorize my doctor and his clinic staff to release my private medical information to all medical sources involved in my care, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

I understand these authorizations will remain in effect until such time I request, in writing, that these authorizations be withdrawn.

A copy of this authorization form shall be considered as valid as the original.

Patient Signature

Print Name: _____

Date

Witness