PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPREHENSIVE PAIN & NEUROLOGY CENTER PLLC
RELIEVE PAIN AND RECLAIM LIFE

Comprehensive Pain & Neurology Center will not disclose your medical records ("PHI" or Protected Health Information) to any party without your signed consent, except as stipulated in our Notice of Privacy Policies and Practices. This form authorizes us to release your medical records to the parties indicated by you.

Your Name: _____ Date of Birth: _____

AUTHORIZED PARTIES

By signing below, I authorize Comprehensive Pain & Neurology Center, PLLC, its agents and employees **("Provider")**, to use and/or disclose any and all of my protected health information of any kind and description to the following party or parties **("Recipients")**:

	PARTY	**RELATIONSHIP TO YOU**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION AND SUBSTANCE ABUSE INFORMATION

I understand that neither Provider nor Recipient may condition any treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug or alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rule prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RIGHT OF REFUSAL

I acknowledge that I have had the opportunity to review Comprehensive Pain & Neurology Center's Notice of Privacy Policies and Practices, which is displayed for public inspection at is facility and on its website at www.tnpainexperts.com.

Comprehensive Pain & Neurology Center's Notice of Privacy Policies and Procedures describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Comprehensive Pain & Neurology Center. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

Privacy Officer
Comprehensive Pain & Neurology Center
2548 Rideout Lane
Murfreesboro, TN 37128

EXPIRATION

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for as long as the Patient is a Patient of the Provider. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

PATIENT'S SIGNATURE

_____ _____
Signature of Patient or Legal Guardian Today's Date

_____
Relationship to Patient