



Comprehensive Pain Management
Minimizing pain. Changing lives.

9118 Bluebonnet Centre Blvd.
Baton Rouge, LA, 70809

P 225-368-2300 F 225-368-2280
www.thepainspecialist.com

Sandra R. Weitz, M.D Alpesh D. Patel, MD Elizabeth Russo-Stringer, MD

**CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION,
AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I allow all disclosures/communications as described in this notice: Exception(if any) below:

Exception
(patient signature on back of form)

relationship

specific restriction

1. Patient Consent for Use and Disclosure of Protected Health Information (“PHI”)

I, the undersigned patient, give my consent to my physician(s), the legal entity in which my physicians practice, and their agents to use or disclose my protected health information (“PHI”) to carry out treatment, payment, or health care operations. These individuals and entities (“provider”) can release, use, or disclose my PHI, including medical records and psychological reports, to other physicians, non-physician providers such as nursing staff, nurse practitioners, physician assistants, therapists, and X-ray personnel, in addition to clearing houses who process my claims, payers who pay my claims and their agents, HMO’s, PPO’s, medical billing companies, and other such entities or persons as are related to my treatment, payment, and the health care operations of my physician’s group, as determined in the sole discretion of my physician and/or his/her group, and their respective agents.

2. Permission to Release or Obtain Medical Records

If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers. I also agree that any physician who is treating me, or who has examined me, whether dead or alive, including the coroner, may release medical records regarding me to the physicians listed hereinabove.

3. Permission to Release Billing Information to Certain Persons Over the Telephone

I agree, as part of this consent for payment operations, that the provider, its group, and their billing personnel, billing agents, or management company can disclose billing information to any person that calls with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number.

4. **Permission to Call and Leave Voice Mail Messages**

I agree that the provider or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

5. **Permission to Discuss Protected Health Information**

I agree that the provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional, or spiritual care, including, but not limited to family, friends, clergy, and patient advocates. I also agree that the provider, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

6. **Permission to Discuss Protected Health Information Regarding Minors**

I agree that the provider, his/her anesthesia group, and their agents may discuss my child's PHI with the child's parent, guardian, or person accompanying the child to the provider's office. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI.

7. **Permission to Discuss Protected Health Information With Public Agencies**

I agree the provider and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

8. **Acknowledgment of Receipt of Notice of Privacy Practices**

I acknowledge that I have received from this provider a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this provider's privacy practices and my rights regarding privacy of my PHI.

9. **Duration of Consent**

I agree that my consent for release of my PHI shall apply all past, present, and future medical records, without new consents being signed by me, and shall last until the earlier of the date I provide written notice of termination of my consent hereto, or 90 days after my death.

PATIENT SIGNATURE
Or Personal Representative
rev 2/2009

DATE