Integrated Pain Solutions

Patient Health Information Consent Form

This form is to obtain your consent to Integrated Pain Solutions use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations. This also provides you the option to consent to our Doctors for use and disclosure of your information to persons involved in your care under Wisconsin's patient confidentiality statute governing the use and disclosure of patient health care records:

- You have been provided the opportunity to receive a copy of our Notice of Privacy Practice. You have the right to read this Notice before you decide whether to sign this consent.
- The Notice includes a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.
- We have reserved the right to change our privacy practices as described in our notice.
- This consent is effective unless and until it is revoked by you in writing. Such revocation will *not* affect any action we took in reliance on this consent before we received your revocation. Upon revocation we may decline to continue treating you.
- You are entitled to a copy of this form upon your signature. Please indicate to the clinic representative if you wish to have a copy.
- This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.
- Unless indicated by you otherwise, Integrated Pain Solutions may use professional judgment and experience with common practice to make reasonable inferences of my best interest in allowing a person acting on your behalf to pick up medical supplies, X-rays, or other similar forms of protected health information.

You may also consent to our use and disclosure of patient health care records for the purposes indicated below by checking the appropriate box.

☐ I consent to your disclosure of my patient health care records for disaster relief purposes as permitted by law.

☐ I consent to your use and disclosure to the following persons, including those involved in my care or payment for that care. (Indicate family member, friend, etc.): ______________________________

<u>Signature</u>

I, ______________________________, have had the opportunity to read and consider the contents of this consent form and your Notice of Privacy of Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Signature: ______________________________ Date: ______________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: ______________________________ Relationship to Patient: ____________________

FOR OFFICE USE ONLY: *If unable to obtain acknowledgment from patient, describe the good faith effort to obtain patient's signature. If known, provide the reason the patient would not sign this form:*

Clinic Representative: *Date:*

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