



Palmetto

Spine & Pain Care Consultants

HIPPA Disclosure Authorization Form

Patient Name: _____

I hereby authorize Palmetto Spine and Pain Care Consultants to use or disclose my protected health information related to Pain Management Treatment to _____ for the following purposes: _____

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been take in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may be subject to federal or state laws protecting its confidentiality.

Date

Signature of Individual or Representative

Authority or Relationship to Individual