ST. LOUIS NEUROPATHY AND PAIN RELIEF CENTER

HIPAA – Patient Consent for Disclosure of Protected Health Information

10777 Sunset Office Drive, Suite 40
St. Louis, MO 63127
(314) 222-0060

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Clinic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Clinic has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Clinic reserves the right to change the Notice of Privacy Practices.
- Patient has the right to restrict uses of their information but the Clinic does not have to agree to the restrictions.
- Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

_____ _____
Signature - Patient or Patient's Representative *Signature Date*

_____ _____ _____
Printed Name *Date of Birth* *Date(s) of Service*

Relationship to Patient
(if other than patient): _____

Witness:

_____ _____
Printed Name - Clinic Representative *Signature Date*

Who may receive these records:

_____

Fax #: _____