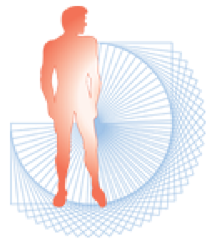

HIPAA Authorization for Use and Disclosure of Protected Health Information

1. I hereby authorize Central Florida Pain Management to use and/or disclose the protected health information about me described below ("**PHI**") to ______________________.

2. The PHI that may be used and/or disclosed is ___________________________ ____.

3. The PHI may be used and/or disclosed for the following purpose: __________ ____.

4. This authorization shall remain in effect until: ___________________________.

5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this form.

6. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that Central Florida Pain Management has acted in reliance upon it, by sending written notification to: ____.

7. I understand that I have the right to refuse to sign this authorization.

8. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

__________________________	__________________________
Signature	Date
__________________________	__________________________
Name	Relationship or Authority of Personal Representative (if applicable)*

*This may be signed by a legal representative of the individual, only if the individual is a minor or an incompetent, or the beneficiary or personal representative of a deceased individual.