Innovative Pain Solutions Centers

(Interventional Pain Specialists)

Bowie Location: 6911 Laurel Bowie Rd., Ste.212, Bowie, MD 20715

(P) 301.755.9500 (F) 301.747.6017

Salisbury Location: 201 Pine Bluff Rd., Ste.1, Salisbury, MD 21801

(P) 410.648.2000 (F) 410.946.8360

HIPPA Agreement

I understand that as part of the provision of healthcare services, Innovative Pain Solutions Centers will create and maintain health records and other information describing among other things, my health history, symptoms, examination, test results, diagnosis treatment, and any plans for future care or treatment.

I have been provided with the Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon my request, I will be provided with any revised Notice of Privacy Practices.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and services and auditing functions, etc) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with understanding that:

1. Any and all records, whether written or oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment, or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment, payment, or healthcare operations, be restricted. I also understand that the Innovative Pain Solutions Centers and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Name: Patient/Authorized Representative: **Date:**

Signature: Patient/Authorized Representative: **Date:**

Name & Signature: Witness: **Date:**
