HIPAA PRIVACY AND FAMILY DISCLOSURE

IF ANY PERSON OTHER THAN YOURSELF (EXCLUDING PHYSICIANS) EVER WANTS TO CONTACT ADVANCED PAIN MEDICINE ASSOCIATES ON YOUR BEHALF, FOR ANY REASON, YOU MUST LIST THEM BELOW.

Patient Name:	**Phone:**
Social Security:	**Date of Birth:**

I authorize Advanced Pain Medicine Associates to discuss and/or release information to the following individuals:

Name(s) of Authorized Person(s):	Relationship to Patient:	Access Type Granted: (CIRCLE ONE)
		Complete Access Financial Only Medical Only
		Complete Access Financial Only Medical Only
		Complete Access Financial Only Medical Only

If you are not available may we leave a detailed voice message on all numbers listed on record? o NO o YES

I acknowledge that I have received a copy of the Notice of Privacy Practices. o YES o DECLINED COPY

In signing this authorization, I understand and acknowledge the following:

A. I understand that this authorization is voluntary and I am not required to sign it.
B. I understand that I may revoke this authorization by notifying Advanced Pain Medicine Associates in writing of my desire to do so.

Date: Signature of Patient/Legal Representative: