

PAIN MANAGEMENT TREATMENT AGREEMENT

When other pain management treatment options are unavailable or have proven ineffective, opioid (narcotic) medications may be considered to improve quality of life, as well as the ability to function and work. While all medications have possible side effects, opioid medications are potentially more dangerous with respect to side effects and/or risks. To ensure safe usage and pain control, proper monitoring through drug testing is required. The following stipulations are mandatory for all patients to receive pain management treatment at the Institute.

NON-COMPLIANCE WITH ANY ONE OF THESE CONDITIONS MAY RESULT IN DISCHARGE FROM THE PRACTICE.

POTENTIAL SIDE EFFECTS OF OPIOID (NARCOTIC) MEDICATIONS:

The following list includes the most common, but not all, side effects associated with the use of opioid medications:

- Addiction (cessation triggers withdrawal symptoms such as increased pain, agitation, nausea, diarrhea)
- Appetite decrease or loss
- Balance and/or co-ordination disruption
- Confusion and/or difficulty thinking, concentrating, focusing clearly
- Constipation
- Increased drowsiness/sleepiness
- Respiratory depression (breathing too slowly)
- Psychological dependence (cessation triggers craving/depression)
- Tolerance (pseudo-addiction; increased amounts of a medication are needed to control pain)

PATIENTS RECEIVING OPIOID (NARCOTIC) TREATMENT MUST AGREE TO ALL OF THE FOLLOWING:

- I WILL OBTAIN ALL PRESCRIPTIONS FOR OPIOIDS (NARCOTICS) ONLY FROM LOUISIANA SPINE AND PAIN INSTITUTE (LSPI).
- I WILL USE ONLY ONE PHARMACY TO FILL OPIOID PRESCRIPTIONS: _____.
- I WILL IMMEDIATELY NOTIFY MY LSPI PHYSICIAN IF FOR ANY REASON ANOTHER PHARMACY IS USED.
- I WILL TAKE ALL MEDICATIONS PRESCRIBED BY MY LSPI PHYSICIAN ONLY AS DIRECTED.
- I WILL NOT SHARE, GIVE, ALLOW OTHERS TO CONSUME OR PHYSICALLY REMOVE MY MEDICATIONS.
- I UNDERSTAND THAT LSPI DOES NOT REPLACE LOST OR STOLEN OPIOID (NARCOTIC) PRESCRIPTIONS/MEDICATIONS.
- I WILL NOT ACCEPT ANY PAIN MEDICATION FROM ANOTHER PHYSICIAN.
- I WILL NOTIFY ANY/ALL OTHER PHYSICIANS OF MY OPIOID TREATMENT PRESCRIBED BY MY LSPI PHYSICIAN.
- I WILL NOT SEEK EMERGENCY TREATMENT FOR THE CHRONIC PAIN CONDITION MY LSPI PHYSICIAN IS TREATING.
- I WILL IMMEDIATELY NOTIFY MY LSPI PHYSICIAN IF I RECEIVE EMERGENCY/OTHER MEDICAL TREATMENT FOR ANOTHER REASON.
- I WILL KEEP ALL OFFICE APPOINTMENTS. OPIOID PRESCRIPTIONS ARE NOT REFILLED WITHOUT AN OFFICE VISIT AND I MAY EXPERIENCE MEDICATION WITHDRAWAL SYMPTOMS IF I MISS MY APPOINTMENT.
- I WILL ACTIVELY PARTICIPATE IN OTHER, ADDITIONAL PAIN THERAPIES AS RECOMMENDED BY MY PHYSICIAN.
- I ACCEPT RESPONSIBILITY TO GRADUALLY INCREASE MY DAILY ACTIVITIES AS RECOMMENDED BY MY PHYSICIAN.
- I DO NOT NOW, NOR HAVE I EVER, HAD A PROBLEM WITH SUBSTANCE ABUSE OR MEDICATION DEPENDENCE
- I AM NOT PREGNANT; HOWEVER, I WILL NOTIFY MY LSPI PHYSICIAN IMMEDIATELY IF I BECOME PREGNANT.
- I UNDERSTAND I WILL BE SUBJECT TO RANDOM DRUG TESTING AND RANDOM PILL COUNTS. IF I REFUSE MY LSPI PHYSICIAN HAS THE RIGHT TO WITHHOLD ANY/ALL MEDICATION, AS WELL AS DISCHARGE ME FROM THE PRACTICE.
- I WILL BE COURTEOUS AND RESPECTFUL TO OFFICE STAFF AND OTHERS

OPIOID TREATMENT WILL BE DISCONTINUED IF ANY OF THE FOLLOWING OCCUR:

- MY LSPI PHYSICIAN FEELS THAT OPIOIDS ARE INEFFECTIVE IN RELIEVING MY PAIN OR IMPROVING MY FUNCTIONALITY.
- I VIOLATE THIS AGREEMENT BY SHARING/GIVING/SELLING/LOSING MY MEDICATIONS, OR ALLOWING THEM TO BE STOLEN.
- I FAIL TO TAKE MY MEDICATIONS AS DIRECTED.
- I OBTAIN OPIOID MEDICATIONS FROM SOURCES OTHER THAN MY LSPI PHYSICIAN.
- I ABUSE OTHER SUBSTANCES, LEGAL OR ILLEGAL (ALCOHOL, COCAINE, MARIJUANA, NARCOTICS, ETC).
- IF ANOTHER CONDITION ARISES THAT PROHIBITS/ CONTRAINDICATES CONTINUING OPIOID TREATMENT.

PRESCRIPTION REFILL POLICY

- **OPIOID PRESCRIPTION REFILLS ARE AVAILABLE ONLY THROUGH A SCHEDULED VISIT DURING REGULAR OFFICE HOURS, (MONDAY-FRIDAY, 8:00 A.M. TO 5:00 P.M.).**
- **IT IS MY RESPONSIBILITY TO PLAN AHEAD AND ARRIVE FOR OFFICE VISITS AS SCHEDULED AND TAKE MY MEDICATIONS AS DIRECTED TO PREVENT RUNNING SHORT OF MEDICATION BEFORE MY NEXT APPOINTMENT.**

AUTHORIZATION AND CONSENT

I consent for my LSPI physician and office staff to communicate directly with my pharmacy or other organizations to obtain information regarding my prescription history. I agree to waive any applicable privilege or right of confidentiality with respect to the prescribing of my pain medication. I authorize my LSPI physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Louisiana Board of Pharmacy, in the investigation of my possible misuse, sale, or diversion of my pain medication. I authorize a copy of this agreement to be provided to my pharmacy and other health care providers as needed.

I understand that the random drug screen testing results may be released to my other healthcare providers, insurance company, or other reimbursing agencies. I also authorize any other healthcare provider, pharmacy, and law enforcement or judiciary body to release any pertinent information regarding my prescriptions or urine/blood drug screen testing results.

My failure to follow the Treatment Plan as outlined by my LSPI physician indicates I no longer agree with the Treatment Plan and will result in my being discharged from the practice.

If I refuse to sign the treatment agreement, I understand that I WILL NOT be treated for pain management at Louisiana Spine and Pain Institute

Termination Clauses

My LSPI physician may terminate this agreement at any time if he/she believes 1) I am not complying with its terms, 2) if I have made a material misrepresentation or false statement concerning my pain or 3) falsely states my compliance with the terms of this agreement.

The patient may terminate this agreement at any time.

If this agreement is terminated, the doctor/patient relationship is terminated and the patient will be formally discharged from the facility. Thus, the patient cannot and will not be treated by another physician associated with the practice.

I, the undersigned, attest that the above agreement was discussed with me, and I fully understand and agree to ALL of the conditions, requirements and instructions. I also understand that failure to comply with the above may result in my discharge from this practice.

Patient Name: _____ **(Please Print) Date:** ____/____/20____

Patient/ Guardian Signature: _____ **Witness Signature:** _____

Authorization for Treatment

I hereby authorize the physician(s) of the Louisiana Spine and Pain Institute to disclose any or all of the information in my records to any person, corporation or agency which is or may be liable for all or part of the Louisiana Spina and Pain Institute's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the health maintenance organizations, preferred provider organizations, worker's compensation carriers, welfare funds, the social security administration or it's intermediaries or carriers. I understand that my medical records may contain hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning my identity and release the Louisiana Spine and Pain Institute, its agents, and its employees from liability in connection with the release of information contained therein.

Patient/ Guardian Signature: _____

New Patient Intake form

Name: _____ **Date:** _____

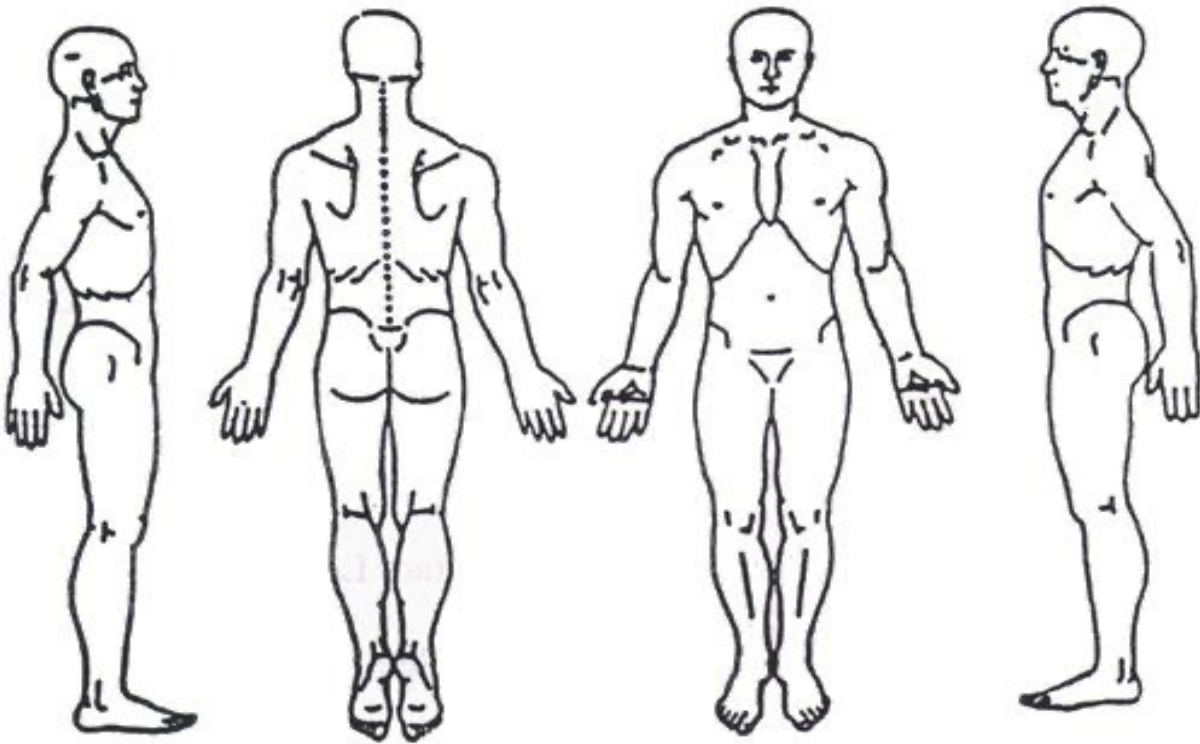
Primary Care Physician: _____ **Referring Physician:** _____

Please list all Medications you are currently taking (including dosage)

_____	_____
_____	_____
_____	_____

Please circle if you take Coumadin, Warfarin, Plavix, Lovonox or Aspirin. If Yes, last dose? _____

Shade the areas in which you have pain:



Characteristics of your pain:

Pain intensity (0= no pain, 10= worst pain ever)

Please list number that best describes your pain

I do not have any other symptoms

Average pain _____

Worst pain _____

With activity _____

Associated Systems, please circle if applies to you

Fatigue

Loss of bladder/bowel control

Nausea

Numbness

Tingling, burning or pricking feeling

Spasm or Weakness

Circle activities that make pain worse:

All activities
Bending forward
Exertion/ Exercise
Getting out of chair
Lifting
Lying down
Moderate Physical Activity
Nonspecific activity
Position change
Reaching
Significant Physical Activity
Sitting
Standing
Turning the head
Twisting
Walking
Other: _____

Circle activities that make pain better:

None
Bending forward
Injections
Lying down
Medications
Moving
Position change
Physical activity
Procedures
Rest
Sitting
Standing
Other: _____

Circle the qualities of your pain:

Aching
Burning
Dull
Sharp
Shooting
Stabbing
Throbbing
Pressure
Crushing
Cramping
Spasmodic
Pulling
Tender
Tight
Knife like
Hot
Sore

Circle the duration of you pain:

Constant
Intermittent

If you are allergic to anything please list below:

Circle any conditions you have:

Headaches	Gallstones	Hepatitis	Bladder Cancer
Migraines	GERD	HIV	Breast Cancer
Seasonal Allergies	GI Bleed	Shingles	Colon Cancer
Sinusitis	Hiatal Hernia		Lung Cancer
	Irritable Bowel Syndrome	Stroke	Melanoma
Angina	Pancreatitis	Parkinson's Disease	Prostate Cancer
Arrhythmia	Ulcers	Seizure Disorder	
Coronary Artery Disease		TIA	Back Pain
Deep Venous Thrombosis			Connective Tissue Disorder
High Blood Pressure	Enlarged Prostate	ADD	Fibromyalgia
High Cholesterol	Frequent Bladder Infections	Anxiety	Kyphoscoliosis
Past Heart Attack	Kidney Stones	Bipolar Disorder	Osteoarthritis
Mitral Valve Prolapse	Renal Failure	Dementia	Osteoporosis
Heart Murmur	Renal Insufficiency	Depression	Rheumatoid Arthritis
Pacemaker		Schizophrenia	Scoliosis
Peripheral Vascular Disease			
Asthma	Diabetes	Anemia	
COPD	Obesity	Bleeding Disorder	
Obstructive Sleep Apnea	Thyroid Disease	Transfusions	

List all past surgeries followed by approximate dates:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Circle Prior Treatments:

"X" if it was helpful

Details

Acupuncture	_____	_____
Biofeedback Relaxation Therapy	_____	_____
Botox Injections	_____	_____
Chiropractic	_____	_____
Heat	_____	_____
Home Exercise	_____	_____
Ice	_____	_____
Massage	_____	_____
Minimally Invasive Procedures	_____	_____
Occupational Therapy	_____	_____
Physical Therapy	_____	_____
Surgery	_____	_____
TENS	_____	_____

Louisiana Spine and Pain Institute

4600 Sherwood Common Blvd, Suite 401, Baton Rouge, Louisiana 70816

Circle all medication taken for your pain in the past:

“X” if it helped

Details

NSAIDS	_____	_____
Celebrex	_____	_____
Diclofenac	_____	_____
Flector Patch	_____	_____
Ibuprofen	_____	_____
Mobic	_____	_____
Nabumetone	_____	_____
Naproxen	_____	_____
Voltaren gel	_____	_____
Flexeril	_____	_____
Skelaxin	_____	_____
Soma	_____	_____
Zanaflex	_____	_____
Actiq	_____	_____
Hydrocodone	_____	_____
Hydromorphone	_____	_____
Percocet	_____	_____
Duragesic	_____	_____
Methadone	_____	_____
Morphine	_____	_____
Oxycontin	_____	_____
Oxymorphone	_____	_____
Cymbalta	_____	_____
Lyrica	_____	_____
Neurontin	_____	_____
Savella	_____	_____
Topamax	_____	_____
Trileptal	_____	_____
Lidoderm Patch	_____	_____
Tramadol	_____	_____
Tylenol	_____	_____
Blood thinners	_____	_____
Other Medications:	_____	_____
_____	_____	_____
_____	_____	_____

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Circle what applies:

Single Married Domestic Partner Widowed Separated Divorced Number of Children _____ Ages of Children _____ Retired Disabled Unemployed Self-employed Employed Part Time Employed Full Time Current Occupation _____ Previous Occupation _____ Circle Highest Level of Education Elementary Education Some High School High School Diploma GED Some College College Degree Master's Degree Doctorate Degree	Currently smoke every day Currently smoke some days Former Smoker Never Smoker Cigarette Packs per day _____ Cigars per day _____ Pipe times per day _____ Chew cans per day _____ Total Years _____ No Alcohol Use Rarely Use Alcohol Socially Use Alcohol Daily Use Alcohol Details _____ I do not use recreational drugs I use Marijuana I use Cocaine I use Heroin I use Morphine I use Methamphetamines I use LSD I use Mushrooms I use Ecstasy I use _____	I never exercise I exercise 1-2 times per week I exercise 3-5 times per week I exercise 6-7 times per week Type of Exercise I do: Aerobics Biking Running Hiking Swimming Climbing Treadmill/Elliptical Walking Weight Lifting Other _____
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Family History place an "X" if this relative has the following:

	Father	Mother	Sister	Brother	Other
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Congestive Heart Failure	_____	_____	_____	_____	_____
COPD	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Irritable Bowel Syndrome	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____	_____
Peripheral Artery Disease	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Circle if you have the following:

Depression	Describe: _____
Anxiety	Describe: _____
Psychosis	Describe: _____

Circle what applies:

I am currently not in treatment
I am currently seeing a psychiatrist
I am currently seeing a psychologist

I have had thoughts of suicide
I have not had thoughts of suicide

I am coping with my chronic pain
I am frustrated with my chronic pain

Circle all that apply to you:

Fever	Joint Pain
Chills	Joint Swelling
Fatigue	Stiffness
Poor Appetite	Weakness
Weight Gain	Abdominal Pain
Weight Loss	Nausea
Hearing Loss	Vomiting
Sore Throat	Diarrhea
Blurred Vision	Heartburn
Decreased Vision	Constipation
Shortness of Breath	Sexual Problems
Wheezing	Problems Urinating
Cough	
Chest pain	Headaches
Irregular Heart Beats	Dizziness
Swelling in Leg	Loss of Consciousness
	Weakness
Rash	Numbness
Itching	Tingling
Lesions	
Bruise Easily	Depression
	Anxiety

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NAME (last, first, middle): _____ TITLE: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED NAME: _____ SS#: _____ - _____ - _____ DOB: ____/____/____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

*EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

MEDICAL ALERTS: _____

DO YOU HAVE AN ADVANCE DIRECTIVE? (PLEASE CIRCLE ONE) YES NO or DNR

IS YOUR PAIN A RESULT OF A MOTOR VEHICLE ACCIDENT? (PLEASE CIRCLE ONE) YES or NO

ARE YOU CURRENTLY INVOLVED IN A LAWSUIT REGARDING YOUR CURRENT PAIN? YES or NO

EXPLAIN: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER ADDRESS: _____

SS# _____ - _____ - _____ EMPLOYER: _____

DOB: ____/____/____ ADDRESS: _____

INSURANCE CO: _____ ID#: _____

ADDRESS: _____ GROUP: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER ADDRESS: _____

SS# _____ - _____ - _____ EMPLOYER: _____

DOB: ____/____/____ ADDRESS: _____

INSURANCE CO: _____ ID#: _____

ADDRESS: _____ GROUP: _____

I understand that I am financially responsible for payment of this account and/or charges not covered by my insurance.

PATIENT SIGNATURE: _____ DATE: _____

EXPLANATION OF HIPAA

The Health Insurance Portability and Accountability Act of 1966 (HIPAA) requires an Authorization to Release Medical Information in order for health care providers to release medical information or records. New requirements for authorizations became effective April 16, 2003. This requirements also extends to organizations closely associated with health care providers, and their contractors. It is necessary to use this form when requesting information from health care providers because this law requires specific information to be provided on an authorization. This form should not be used to request records not covered by HIPAA (records obtained from a source other than a health care provider).

Medical Providers are mandated to protect information and to require the use of forms that comply with the law. This form complies with the requirements of HIPAA and should be accepted by all medical providers. However, if a medical provider insists that the provider's form be used, you may want to use that form if it will expedite the process of obtaining records. Please notify the AWPPW if this situation arises so that the problem can be resolved.

Requirements for using this form:

HIPAA also requires specific steps in obtaining and utilizing an authorization to release medical information. Therefore, it will be necessary that you:

- Utilize one form for each medical provider from whom records are requested.
- Complete the forms in their entirety before asking a client to sign.
- Date the form at the time it is signed.
- Provide a copy of each completed form to the client.

Note on records authorized to be released

All types of notes that you may need to request at any time from a particular provider should be checked. Otherwise, you may need to have another authorization signed before requesting additional records. There may be additional issues with some particular types of records.

- Records related to HIV status may not be released unless the individual has signed a separate release specific to HIV related information. 5 U.S.C. §19203-D.
- Psychotherapy notes may not be released unless the individual has signed a separate release specifying that such notes may be released. 45 C.F.R. §164.508(b)(3)(ii)
- You must specify on the authorization the extent or nature of records to be released for drug or alcohol records. 42 U.S.C. 290dd-3; 42 U.S.C. 290ee-3; 42 C.F.R., Part 2. The individual may also use this section to limit other records to be released.
- 'Medication administration logs...' relates to information that is not part of an individual's medical record. Such information that is not a part of an abuse/neglect investigations but must be specifically requested and have other patients' information redacted. This is time-consuming and costly, and such records should only be requested if necessary to investigate the specific allegations or serious incident.

Note on statement of purpose

This statement of purpose should reflect the reason for the request. The client may elect to check the last statement 'other activities at the request of the individual' if desired.

Note on patient representatives

If patient's representative is signing the authorization, you must specify the relationship of the representative to the patient. Common relationships include:

- Parent or Guardian
- Conservator (a copy of the order appointing the conservator should also be provided)
- Attorney-in-fact (a copy of the notarized Power of Attorney should also be provided)
- Administrator of an Estate (a copy of the letters of administration from the court should also be provided)

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment, of my bills or in the performance of Ayman Hamed M.D.'s health care operations. The Notice of Privacy Practices is posted at the front desk and on our website at www.hamedmd.com.

Ayman Hamed, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of next appointment, or accessing Ayman Hamed, M.D.'s website.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (print)

Date

Description of Personal Representative's Authority

ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance(s) carriers, including Medicare, private insurance and any other health/medical plan, to issue payment check(s) to Dr. Ayman Hamed, M.D. medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Ayman Hamed to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Ayman Hamed on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that all fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness

Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (LAST, FIRST)

DOB

ADDRESS

SSN

CITY

STATE

ZIP

PROVIDER/FACILITY AUTHORIZED TO RELEASE PHI

ENTITY RECEIVING THE PHI

NAME

NAME

ADDRESS

ADDRESS

CITY

CITY

STATE

ZIP

STATE

ZIP

PHONE

FAX

PHONE

FAX

225-767-1390

225-767-1391

The Purpose of this Authorization is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

☐

Changing Physicians

☐

Legal Representation

☐

Continued Care

☐

Other activities at the request of the individual

I authorize the release of the following protected health information. (Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐

Entire Record

☐

Laboratory Reports

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

☐

Alcoholism

☐

Vocational rehabilitation

☐

HIV (AIDS)

☐

Sexually Transmitted Diseases

☐

Other

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire within 12 months from date signed.

Date: _____ Event: _____

I UNDERSTAND THAT

1. I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION AND THAT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE RECIPIENT IS NOT HEALTH PLAN OR HEALTHCARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT

Signature of Individual or Personal Representative authorized by law

Date

Personal Representative's Relationship to Patient