HIPAA RELEASE OF INFORMATION
AUTHORIZATION FORM

I, _____hereby authorize ReGen Pain Management, PLLC and its affiliates, its employees and agents, to release my personal health information maintained by Dr. Koning (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) to certain healthcare entities, including but not limited to imaging facilities, laboratories, and physicians involved in my care, except the following information about me:
Please list below any information you DO NOT WANT released:

_____

for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of:

_____ [INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES] or

_____ [INSERT DATE YOUR COVERAGE ENDS WITH CURRENT INSURANCE PLAN]

I understand that I have a right to revoke this authorization by providing written notice to ReGen Pain Management, PLLC. However, this authorization may not be revoked if ReGen Pain Management, PLLC, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
Name of Member: _____
Signature of Member: _____
Date: _____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.
Name of Legal Representative:_____
Signature of Legal Representative: _____
Date: _____
Name of Witness: _____
Signature of Witness: _____