The Painless Center
1608 Lemoine Avenue, Suite 201
Fort Lee, NJ 07024

HIPAA Acknowledgement and Consent Form

I understand that I, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), have certain rights to privacy regarding my protected health information ("PHI"). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Conduct, plan and direct my treatment, and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- To obtain payment from designated third-party payers (e.g. my insurance company).
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed of the Notice of Privacy Practices of The Painless Center. I have reviewed such Notice of Privacy Practices prior to signing this consent. I understand that The Painless Center has the right to change its Notice of Privacy Practices from time to time, and that I may contact The Painless Center at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions; however, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time; however, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____