Consent For Treatment

IT TAKES A VILLAGE

I voluntarily give my permission to the health care providers of It Takes a Village Pain Management Practice of New York (ITAV) and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from ITAV Pain management or until I withdraw my consent in writing.

I give my consent ITAV to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review ITAV's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize ITAV to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize ITAV to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that ITAV signing this also qualifies as a "Patient Release Of Medical Information" form and that upon my future notification to ITAV, ITAV can release my Protected Health Information to any other party (including family) I so direct.

Signature of Patient or Guardian.____

Date:____

Printed Name of Patient or Guardian: ____

Relationship to Patient:____

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