PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, Valley Pain Center, or the office staff, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Valley Pain Center's, or the office staff's, Notice of Privacy Practices for a more complete description of such consent. Valley Pain Center, or the office staff, reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Valley Pain Center's Privacy Officer at 425 E. Los Ebanos Blvd. Suite# 105, Brownsville, Texas 78520.

With my consent, Valley Pain Center may call my home or other designated location and leave a message or voicemail or in person in reference to any items that assist the practice in carrying out clinical care, including laboratory results among others.

With my consent, Valley Pain Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statement.

With my consent, Valley Pain Center may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Valley Pain Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.

Federal Rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

By signing this form, I am consenting to Valley Pain Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice had already made disclosures in reliance upon prior consent. If I do not sign this consent, Valley Pain Center may decline to provide treatment to me.

____
Patient's Name

____
Signature of Patient or Legal Guardian

I acknowledge that I have been provided with a Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

____________________________ ____________________________
Signature of Patient Date