JLR PAIN MEDICINE

2056 Aloma Avenue, Ste. 101, Winter Park, FL, 407-478-0007, Fax 407.478.4517

CONSENT TO RELEASE INFORMATION

I hereby given my consent to JLR Pain Medicine to release any information regarding my care and treatment as may be required by any insurance carrier in connection with payment by the insurance carrier of any portion of my bill.

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be rendered directly to JLR Pain Medicine for the benefits otherwise payable to me be any third party. The above authorizations are in effect permanently or until canceled by myself in writing.

X_____ _____
Patient/Authorized Signature Date

MEDICARE SIGNATURE ON FILE

I request that payment under the medical insurance program Medicare be made to either me of JLR Pain Medicine on any bills for services furnished me by those physicians permanently or until this authorization is canceled by myself in writing. I also give JLR Pain Medicine authorization to file claims to Medicare on my behalf.

X_____ _____
Insured/Authorized Signature Date

JLR PAIN MEDICINE
2056 ALOMA AVE., STE 101
WINTER PARK, FL 32792
407-478-0007

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your rights and our obligations regarding the use and disclosure of your medical information.

Parties Following The Notice: The Notice will be followed by the Plan, persons involved in administering the Plan, and other legal entities that provide services to the Plan.

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons, including:

*Treatment
*Payment
*As required by law
*Worker's Compensation
*Lawsuits and disputes
*Law enforcement purposes
*National security and protective services
*To the Plan Sponsor
*To avert a serious threat to health or safety
*To coroners, medical examiner and funeral directors
*To military command authorities
*Organ donation
*Health care operation
*Health oversight activities
*Public health purposes
*Auditing

In general, other uses and disclosure of your medical information will require your written authorization. We may use or disclose certain limited information about you, **unless you object or request a limitation of the disclosure for:**

*Hospital directories
*Individuals involved in your care or payment

Your Privacy Rights:
You have the following rights with request to your health information:

*The right to request confidential communications and alternative means of communication with you.
*The right to request restrictions on certain uses of your health information.
*The right to inspect and copy certain medical information that we maintain about you.
*The right to request an amendment of your health information.
*The right to an accounting of certain disclosures of your health information.

Changes to the Notice: We reserve the rights to change the Notice. We will post any revised Notice in the Office.
Complaints: If you believe your rights have been violated you may file a written complaint with Our Office Manager **OR WITH THE SECRETARY OF THE U.S. DEPT OF HEALTH AND HUMAN SERVICES. IN ADDITION, YOU MAY CALL THE HEALTHCARE VALUES LINE: 1-800-273-8453.**

ACKNOWLEDGMENT

Patient Name:_____Date:_____

Patient Acknowledgment: I acknowledge that I have received a copy of the Notice of Privacy Practices for JLR Pain Medicine. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Signature of Patient:(x)_____Date:_____

For Use by Staff Personnel Only: (Complete if patient acknowledgement is not obtained)
The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgment was not obtained because _____
_____.

Signature of Clinic Representative_____Date:_____