AMARILLO INTERVENTIONAL PAIN MANAGEMENT
HIPAA AUTHORIZATION FORM

I, ____________________, give permission to Amarillo Interventional Pain Management to:

_ use the following protected health information, and/or
_ disclose the following protected health information to (please list names of any person(s) other than yourself that you would like to be able to receive information about your protected health information):
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____

Information to be disclosed (check all that apply):
_ Medical Records
_ Treatment Records
_ Diagnostic Records
_ Billing Records
_ Other: ____
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This protected health information is being used or disclosed for the following purposes:
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- This authorization expires within 12 months of the date, which this form was signed.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
- You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.
- You may inspect or copy the protected health information to be used or disclosed under this authorization.
- Finally, you may revoke this authorization in writing at any time by sending written notification to Haley Jones (privacy officer for Dr. Victor Taylor) at 7901 SW 34th Ave., Amarillo, TX 79121. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.
- I have received or been offered a copy of Amarillo Interventional Pain Management's Privacy Policy.

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Signature of Participant or Personal Representative

Printed Name of Participant or Personal Representative

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Date Description of Personal Representative's Authority